

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0049809</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>PAVILION OF WAUKEGAN</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>2217 S. WASHINGTON</u> <u>WAUKEGAN</u> <u>60085</u>			
Number City Zip Code			
County: <u>LAKE</u>			
Telephone Number: <u>(847) 244-4100</u> Fax # <u>(847) 244-2183</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>12/1/07</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>DARRYL BUEKER</u>			
Telephone Number: <u>(417) 865-8701</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u>	
		(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	
		(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number PAVILION OF WAUKEGAN

0049809 Report Period Beginning: 1/1/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,428</u>	<u>1,749</u>	<u>8,348</u>	<u>34,525</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,428</u>	<u>1,749</u>	<u>8,348</u>	<u>34,525</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.78%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/1/07 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 109 and days of care provided 6,237

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/11 Fiscal Year: 12/31/11

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number		PAVILION OF WAUKEGAN				STATE OF ILLINOIS		# 0049809		Report Period Beginning:		1/1/11		Ending:		Page 3	
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)																	
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY							
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10						
	A. General Services																
1	Dietary	215,919	14,396	7,763	238,078		238,078		238,078								1
2	Food Purchase		185,740		185,740		185,740	(47)	185,693								2
3	Housekeeping	131,311	37,840		169,151		169,151		169,151								3
4	Laundry	39,433	11,493		50,926		50,926		50,926								4
5	Heat and Other Utilities			99,057	99,057		99,057		99,057								5
6	Maintenance	78,371	13,169	60,771	152,311		152,311		152,311								6
7	Other (specify):*																7
8	TOTAL General Services	465,034	262,638	167,591	895,263		895,263	(47)	895,216								8
	B. Health Care and Programs																
9	Medical Director			12,000	12,000		12,000		12,000								9
10	Nursing and Medical Records	1,848,884	275,796	4,600	2,129,280		2,129,280		2,129,280								10
10a	Therapy	154,801		558,456	713,257		713,257		713,257								10a
11	Activities	98,652	2,726	13,198	114,576		114,576		114,576								11
12	Social Services	49,551			49,551		49,551		49,551								12
13	CNA Training																13
14	Program Transportation																14
15	Other (specify):*																15
16	TOTAL Health Care and Programs	2,151,888	278,522	588,254	3,018,664		3,018,664		3,018,664								16
	C. General Administration																
17	Administrative	59,923		480,000	539,923		539,923	(256,706)	283,217								17
18	Directors Fees																18
19	Professional Services			128,355	128,355		128,355	7,161	135,516								19
20	Dues, Fees, Subscriptions & Promotions			20,548	20,548		20,548	(5,566)	14,982								20
21	Clerical & General Office Expenses	146,503	13,645	62,915	223,063		223,063	70,985	294,048								21
22	Employee Benefits & Payroll Taxes			513,448	513,448		513,448		513,448								22
23	Inservice Training & Education																23
24	Travel and Seminar			3,744	3,744		3,744	225	3,969								24
25	Other Admin. Staff Transportation			20,318	20,318		20,318	12,666	32,984								25
26	Insurance-Prop.Liab.Malpractice			82,275	82,275		82,275	1,215	83,490								26
27	Other (specify):*							19,022	19,022								27
28	TOTAL General Administration	206,426	13,645	1,311,603	1,531,674		1,531,674	(150,998)	1,380,676								28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,823,348	554,805	2,067,448	5,445,601		5,445,601	(151,045)	5,294,556								29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,914	27,914		27,914	5,776	33,690			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,002	36,002		36,002	1,381	37,383			32
33	Real Estate Taxes			90,000	90,000		90,000		90,000			33
34	Rent-Facility & Grounds			518,863	518,863		518,863	4,028	522,891			34
35	Rent-Equipment & Vehicles			131,110	131,110		131,110	5,115	136,225			35
36	Other (specify):*											36
37	TOTAL Ownership			803,889	803,889		803,889	16,300	820,189			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			491,606	491,606		491,606		491,606			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678		59,678		59,678			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			551,284	551,284		551,284		551,284			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,823,348	554,805	3,422,621	6,800,774		6,800,774	(134,745)	6,666,029			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,064)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,794)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,392)	21		18
19	Entertainment	(293)	21		19
20	Contributions	(17,625)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,982)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,543)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(850)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,590)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(94,155)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (94,155)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (134,745)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning: ID# 0049809

Ending: 1/1/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	\$ 0	20	1
2	MISC INCOME	(850)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(850)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AARON TOPPER	75	CROSSROADS CARE CENTER OF WOODSTOCK	WOODSTOCK	AA HEALTHCARE	SKOKIE	MANAGEMENT
ABRAHAM GUTNICKI	25			MGT, LLC		
				PAVILION OF WAUKEGAN		BUILDING LESSO
				REALTY, LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 518,863	PAVILION OF WAUKEGAN REALTY, LLC		\$ 518,863	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	19	LEGAL FEES	8,687	LAW OFFICE OF ABRAHAM GUTNICKI		8,687		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 527,550			\$ 527,550	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	\$ 360,000	AA HEALTHCARE MANAGEMENT, LLC	100.00%	\$	\$ (360,000)	15
16	V	5	Utilities		AA HEALTHCARE MANAGEMENT, LLC				16
17	V	6	Repairs & Maintenance		AA HEALTHCARE MANAGEMENT, LLC				17
18	V	17	Owners Compensation		AA HEALTHCARE MANAGEMENT, LLC		103,294	103,294	18
19	V	19	Professional Fees		AA HEALTHCARE MANAGEMENT, LLC		7,161	7,161	19
20	V	20	Fees, Subscriptions		AA HEALTHCARE MANAGEMENT, LLC		416	416	20
21	V	21	Clerical Salaries		AA HEALTHCARE MANAGEMENT, LLC		102,003	102,003	21
22	V	21	Office Expenses		AA HEALTHCARE MANAGEMENT, LLC		2,479	2,479	22
23	V	24	Travel & Seminars		AA HEALTHCARE MANAGEMENT, LLC		225	225	23
24	V	25	Transportation		AA HEALTHCARE MANAGEMENT, LLC		12,666	12,666	24
25	V	26	Insurance		AA HEALTHCARE MANAGEMENT, LLC		1,215	1,215	25
26	V	27	Employee Benefits		AA HEALTHCARE MANAGEMENT, LLC		19,022	19,022	26
27	V	30	Depreciation		AA HEALTHCARE MANAGEMENT, LLC		5,776	5,776	27
28	V	32	Interest		AA HEALTHCARE MANAGEMENT, LLC		2,445	2,445	28
29	V	34	Rent		AA HEALTHCARE MANAGEMENT, LLC		4,028	4,028	29
30	V	35	Equipment Rental		AA HEALTHCARE MANAGEMENT, LLC		5,115	5,115	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 360,000			\$ 265,845	\$ * (94,155)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON TOPPER	OWNER/ADMIN	Administrative	75.00	SEE ATTACHED	40	80.00	Mgt Fees	\$ 103,294	17-3	1
2											2
3	AARON TOPPER	OWNER/ADMIN	Administrative	75.00	SEE ATTACHED			Mgt Fees	90,000	17-3	3
4	ABRAHAM GUTNICKI	OWNER		25.00				Mgt Fees	30,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 223,294		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 12/31/11

(847) 673-3379

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3	17	Owners Compensation	Patient Days	66,848	2	200,000		34,525	103,294	3
4	19	Professional Fees	Patient Days	66,848	2	13,865		34,525	7,161	4
5	20	Fees, Subscriptions	Patient Days	66,848	2	806		34,525	416	5
6	21	Clerical Salaries	Patient Days	66,848	2	197,500	197,500	34,525	102,003	6
7	21	Office Expenses	Patient Days	66,848	2	4,799		34,525	2,479	7
8	24	Travel & Seminars	Patient Days	66,848	2	435		34,525	225	8
9	25	Transportation	Patient Days	66,848	2	24,525		34,525	12,666	9
10	26	Insurance	Patient Days	66,848	2	2,353		34,525	1,215	10
11	27	Employee Benefits	Patient Days	66,848	2	36,831		34,525	19,022	11
12	30	Depreciation	Patient Days	66,848	2	11,183		34,525	5,776	12
13	32	Interest	Patient Days	66,848	2	4,735		34,525	2,445	13
14	34	Rent	Patient Days	66,848	2	7,800		34,525	4,028	14
15	35	Equipment Rental	Patient Days	66,848	2	9,903		34,525	5,115	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 514,735	\$ 197,500		\$ 265,845	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	FIFTH THIRD BANK		X	VEHICLE	\$333.71		\$				\$	875	1		
2	ALLY BANK		X	VEHICLE	\$386.46				19,418			119	2		
3													3		
4													4		
5													5		
	Working Capital														
6	LAKE FOREST BANK		X	LINE OF CREDIT					748,745			30,094	6		
7													7		
8	MISC											4,914	8		
9	TOTAL Facility Related				\$720.17		\$		\$	768,163			\$	36,002	9
	B. Non-Facility Related*														
10	INTEREST INCOME OFFSET											(1,064)	10		
11													11		
12													12		
13	ALLOCATION FROM AA HC MGT											2,445	13		
14	TOTAL Non-Facility Related						\$		\$			\$	1,381	14	
15	TOTALS (line 9+line14)						\$		\$	768,163			\$	37,383	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,161

B. General Construction Type: Exterior BRICKFrame STEELNumber of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?☐ YES☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	36,213		\$	1
2					2
3	TOTALS	36,213		\$	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	ELECTRIC		2008		10,292	264	39	264		9,346
10	LANDSCAPING		2008		5,106	255	20	255		4,234
11	DOOR KICKPLATES		2009		1,913	191	10	191		1,419
12	ELEVATOR PUMP		2009		1,462	146	10	146		1,072
13	THERMOSTATIC MIXING VALVE		2009		3,955	101	39	101		3,718
14	DOOR ALARM SYSTEM		2009		1,089	109	10	109		844
15	CIRCULATING PUMP-HOT WATER HEATER		2009		1,041	104	10	104		824
16	SPACE PAK UNIT MOTOR		2010		1,757	176	10	176		1,420
17	LOCKINVAR		2010		8,942	596	15	596		7,899
18	NEW LOCKS		2010		1,417	142	10	142		1,228
19	ELEVATOR ICU CONTROL BOARD		2011		956	72	10	72		884
20	EXIT DOOR DEVICE		2011		814	41	10	41		774
21	SPRINKLER HEADS		2011		540	23	10	23		518
22	BASEMENT TILE FLOORING		2011		964	32	10	32		932
23	PATIO DOOR		2011		2,168	54	10	54		2,114
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$42,416	\$2,306		\$2,306	\$	\$37,226	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$205,209	\$18,618	\$18,618	\$		\$75,318	71
72	Current Year Purchases	57,625	3,716	3,716			3,716	72
73	Fully Depreciated Assets							73
74	Allocation from AA HC Mgt		5,776	5,776				74
75	TOTALS	\$262,834	\$28,110	\$28,110	\$		\$79,034	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2004 TOYOTA CAMRY-DISPOS	2008	\$	\$2,950	\$2,950	\$	4	\$	76
77		2010 TOYOTA CAMRY	2011	19,418	324	324		5	324	77
78										78
79										79
80	TOTALS			\$19,418	\$3,274	\$3,274	\$		\$324	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$324,668	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$33,690	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$33,690	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$116,584	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 131,110 Description: Med Equip 129,047; Dish machine 900; Office equip 1,163
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$		\$ 258,441	\$		\$ 258,441	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			91,045			91,045	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			208,424			208,424	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				370,821		370,821	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RT	10a-03				240			240	12
13	Other (specify): Lab/Dialysis						120,785		120,785	13
14	TOTAL			\$		\$ 558,150	\$ 491,606		\$ 1,049,756	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (54)	\$	1
2	Cash-Patient Deposits	40,286		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,535,067		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,167		6
7	Other Prepaid Expenses	2,377		7
8	Accounts Receivable (owners or related parties)	35,348		8
9	Other(specify):	13,595		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,637,786	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	42,416		15
16	Equipment, at Historical Cost	282,251		16
17	Accumulated Depreciation (book methods)	(84,547)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	7,145		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 247,265	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,885,051	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,209,077	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	117,793		28
29	Short-Term Notes Payable	752,053		29
30	Accrued Salaries Payable	186,477		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,603		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	17,636		36
37	Due Others	(692,380)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,597,259	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,110		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,110	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,613,369	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 271,682	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,885,051	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,986	1
2	Restatements (describe):		2
3	ROUNDING	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,983	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	330,699	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(69,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 261,699	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 271,682	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,919,054	1
2	Discounts and Allowances for all Levels	1,401,714	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,320,768	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	553,552	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 553,552	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	83	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	216,614	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,080	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 246,777	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,064	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,064	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME, DISCOUNTS	2,644	28
28a	GAIN ON DISPOSAL-ASSET	6,668	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,312	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,131,473	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	895,263	31
32	Health Care	3,018,664	32
33	General Administration	1,531,674	33
	B. Capital Expense		
34	Ownership	803,889	34
	C. Ancillary Expense		
35	Special Cost Centers	491,606	35
36	Provider Participation Fee	59,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,800,774	40
41	Income before Income Taxes (line 30 minus line 40)**	330,699	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 330,699	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX RETURN FILED CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,848	2,080	\$ 88,920	\$ 42.75	1
2	Assistant Director of Nursing	1,764	1,923	64,714	33.65	2
3	Registered Nurses	18,081	18,999	558,837	29.41	3
4	Licensed Practical Nurses	13,934	14,756	374,372	25.37	4
5	CNAs & Orderlies	65,201	68,627	730,802	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,619	9,175	154,801	16.87	8
9	Activity Director	1,800	2,032	29,812	14.67	9
10	Activity Assistants	5,066	7,114	68,840	9.68	10
11	Social Service Workers	1,948	2,080	49,551	23.82	11
12	Dietician					12
13	Food Service Supervisor	3,193	3,533	74,227	21.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,140	13,558	141,692	10.45	15
16	Dishwashers					16
17	Maintenance Workers	4,854	5,234	78,371	14.97	17
18	Housekeepers	15,222	15,222	131,311	8.63	18
19	Laundry	3,715	3,715	39,433	10.61	19
20	Administrator					20
21	Assistant Administrator	1,904	2,256	59,923	26.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,282	9,770	146,503	15.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,287	2,521	31,239	12.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,858	182,595	\$ 2,823,348 *	\$ 15.46	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	155	\$ 7,763	01-03	35
36	Medical Director		12,000	09-03	36
37	Medical Records Consultant	95	4,600	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	5	306	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,688	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	287	\$ 26,357		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2) Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount. IL COUNCIL LTC \$11,248.80
- (3) Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

3-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$40,380 Line10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YESNOX

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$59,678

This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$0

Has any meal income been offset against related costs?

N/A

Indicate the amount. \$
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.