

		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>0004234</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>SCOTT COUNTY NURSING CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from _____ to _____ 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.																																																	
Address: <u>PO BOX 11</u> <u>WINCHESTER</u> <u>62694</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>SCOTT</u>																																																			
Telephone Number: <u>217-742-3101</u> Fax # <u>217-742-5603</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>4/19/1971</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☒</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☒	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
IRS Exemption Code _____																																																			
In the event there are further questions about this report, please contact:																																																			
Name: <u>RUBI HOOTS</u>																																																			
Telephone Number: <u>217-742-3101</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>RUBI HOOTS</u>																																																	
		(Title) <u>ADMINISTRATOR</u>																																																	
		(Signed) _____ (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) <u>JOHN L. EYTH</u> <u>PARTNER</u>																																																	
		(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT, FOOTE & FLYNN, LTI</u> <u>1395 LINCOLN AVE, JACKSONVILLE, IL 62650</u>																																																	
		(Telephone) <u>217-245-5121</u> Fax # <u>217-243-3356</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 SCOTT COUNTY NURSING CENTER

0004234 Report Period Beginning: ##### Ending:

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 N/A

	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>49</u>	Skilled (SNF)	<u>49</u>	<u>17,885</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>49</u>	TOTALS	<u>49</u>	<u>17,885</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>1,468</u>	<u>1,468</u>	8
9	SNF/PED					9
10	ICF	<u>9,490</u>	<u>5,503</u>		<u>14,993</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,490</u>	<u>5,503</u>	<u>1,468</u>	<u>16,461</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.04%

D. How many bed-hold days during this year were paid by the Department? 0 (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)
DAY CARE

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 04/19/1971

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 49 and days of care provided 1,468

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: N/A Fiscal Year: 11/30

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

Facility Name & ID Number **SCOTT COUNTY NURSING CENTER** # **0004234** Report Period Beginning: **12/1/2010** Ending: **11/30/2011**
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	164,773	13,819	4,320	182,912		182,912		182,912			1
2	Food Purchase		95,507		95,507		95,507	(457)	95,050			2
3	Housekeeping	85,627	13,337		98,964		98,964		98,964			3
4	Laundry	21,589	4,559		26,148		26,148		26,148			4
5	Heat and Other Utilities			104,384	104,384		104,384		104,384			5
6	Maintenance	23,468	12,745	71,247	107,460		107,460		107,460			6
7	Other (specify):*											7
8	TOTAL General Services	295,457	139,967	179,951	615,375		615,375	(457)	614,918			8
	B. Health Care and Programs											
9	Medical Director			8,625	8,625		8,625		8,625			9
10	Nursing and Medical Records	1,001,730	188,157	192,145	1,382,032		1,382,032	(1,435)	1,380,597			10
10a	Therapy											10a
11	Activities	56,909	5,002	228	62,139		62,139		62,139			11
12	Social Services	24,066		596	24,662		24,662		24,662			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,082,705	193,159	201,594	1,477,458		1,477,458	(1,435)	1,476,023			16
	C. General Administration											
17	Administrative	52,790	15,725		68,515		68,515		68,515			17
18	Directors Fees											18
19	Professional Services			17,720	17,720		17,720		17,720			19
20	Dues, Fees, Subscriptions & Promotions			285	285		285		285			20
21	Clerical & General Office Expenses	39,306			39,306		39,306	6,201	45,507			21
22	Employee Benefits & Payroll Taxes			111,995	111,995		111,995	181,598	293,593			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,707	10,707		10,707		10,707			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			200	200		200	13,019	13,219			26
27	Other (specify):*											27
28	TOTAL General Administration	92,096	15,725	140,907	248,728		248,728	200,818	449,546			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,470,258	348,851	522,452	2,341,561		2,341,561	198,926	2,540,487			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			50,881	50,881		50,881		50,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			676	676		676	(676)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			51,557	51,557		51,557	(676)	50,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			26,828	26,828		26,828		26,828			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,470,258	348,851	600,837	2,419,946		2,419,946	198,250	2,618,196			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	\$ (87)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(457)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(1,348)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(676)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions				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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,568)		\$	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)	200,818		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 200,818		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 198,250		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:
Ending:

ID# 0004234
12/1/2010
11/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

Summary A

11/30/2011

[illegible]

Summary B

11/30/2011

[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

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	21	CLERICAL	\$	SCOTT COUNTY	100.00%	\$ 6,201	\$ 6,201	1
2	V	22	IMRF		SCOTT COUNTY	100.00%	138,528	138,528	2
3	V	22	WORKMAN'S COMPENSATION		SCOTT COUNTY	100.00%	36,365	36,365	3
4	V	22	UNEMPLOYMENT		SCOTT COUNTY	100.00%	6,705	6,705	4
5	V	26	INSURANCE		SCOTT COUNTY	100.00%	13,019	13,019	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 200,818	\$ * 200,818	14

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/1/2010 Ending: 11/30/2011

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/1/2010 Ending: #####

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization SCOTT COUNTY
Street Address COURTHOUSE
City / State / Zip Code WINCHESTER, IL 62694
Phone Number (217-742-3368
Fax Number (217-742-5853

	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	21	BOOKKEEPING	HOURS	2,080	2	\$ 31,003	\$ 25,793	416	\$ 6,201	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	TOTALS					\$ 31,003	\$ 25,793		\$ 6,201	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							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2010 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006		8	
	2007		9	
	2008		10	
	2009		11	
	2010		12	

NOTES:

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: 18,909

B. General Construction Type: Exterior BRICKFrame CONCRETENumber of Stories ONE

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SITE	108,909	1970	\$ 1,567	1
2					2
3	TOTALS	108,909		\$ 1,567	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	49		1971	1971	\$ 174,649	\$ 79	40	\$ 79	\$	174,649	4
5			1971	1971	1,500		20			1,500	5
6			1974	1974	20,633		37			20,633	6
7			1974	1974	16,129		VAR			16,129	7
8											8
	Improvement Type**										
9	ENERGY CONTROL			1983	18,678		20			18,678	9
10	WINDOW REMODELING			1986	1,980		20			1,980	10
11	WATER HEATER			1988	5,453		16			5,453	11
12	ELECTRICAL			1989	13,795		20			13,795	12
13	PARKING LOT			1989	3,480		16			3,480	13
14	DOOR - EAST SIDE			1989	1,565		20			1,565	14
15	SPRINKLER SYSTEM			1989	3,150	126	25	126		2,898	15
16	LIGHTS			1990	3,561		10			3,561	16
17	ROOF			1991	57,367		10			57,367	17
18	GARAGE			1991	9,291	136	20	136		9,291	18
19	FOLDING DOOR			1991	1,751		10			1,751	19
20	ELECTRICAL			1992	3,018		10			3,018	20
21	COUNTER TOP			1992	1,920		6			1,920	21
22	BUILDING ADDITION			1993	142,244	4,741	30	4,741		87,709	22
23	PARKING LOT			1993	10,135		16			10,135	23
24	LAUNDRY			1995	22,174	739	30	739		12,194	24
25	GENERATOR FUEL TANK			1998	4,712	314	15	314		4,239	25
26	ELECTRICAL			1998	1,594		10			1,594	26
27	DINING ROOM			2000	274,460	9,149	30	9,149		105,213	27
28	PATIENT ROOM UPDATE - TILING & FURNITURE			2000	32,985		10			32,985	28
29	FULLY DEPRECIATED FIXED EQUIPMENT			1971	198,138		VAR			198,138	29
30	PATIENT ROOM UPDATE - TILING & FURNITURE			2001	24,779	1,238	10	1,238		24,779	30
31	SPRINKLER SYSTEM			2001	9,800	392	25	392		4,116	31
32	KITCHEN UPDATE - COOLER, VENT			2002	37,053	3,705	10	3,705		35,198	32
33	GENERATOR			2005	13,787	1,379	10	1,379		8,963	33
34	FIRE ALARM UPDATE			2005	28,315	1,416	20	1,416		9,204	34
35	PATIENT ROOM UPDATE - HANDICAP ACCESSIBLE			2010	3,389	338	10	338		507	35
36	FRIENDSHIP GARDEN			2011	53,775	1,268	20	1,268		1,268	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 1,195,260	\$ 25,020		\$ 25,020	\$	\$ 873,910	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	\$ 152,046	\$ 14,812	\$ 14,812	\$	10	\$ 87,002	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 152,046	\$ 14,812	\$ 14,812	\$		\$ 87,002	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	PROGRAM TRANS	VAN CHEV 2009	2009	\$ 55,243	\$ 11,049	\$ 11,049	\$	5	\$ 27,622
77									77
78									78
79									79
80	TOTALS			\$ 55,243	\$ 11,049	\$ 11,049	\$		\$ 27,622

E. Summary of Care-Related Assets				1	2
		Reference			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)			\$ 1,404,116
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 50,881
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 50,881
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 988,534

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$
- Description:

(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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(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.

(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		hrs	\$		\$	\$		\$	1					
2	Licensed Speech and Language Development Therapist		hrs							2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist		hrs							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							9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Other (specify):									12					
13	Other (specify):									13					
14	TOTAL			\$		\$	\$		\$	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	\$ 543,978	\$ 543,978	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 543,978	\$ 543,978	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,567	1,567	13
14	Buildings, at Historical Cost	1,195,260	1,195,260	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	207,289	207,289	16
17	Accumulated Depreciation (book methods)	(988,534)	(988,534)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 415,582	\$ 415,582	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 959,560	\$ 959,560	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO INSURANCE FUND	100,545	100,545	36
37	PAYROLL LIABILITIES	648	648	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 101,193	\$ 101,193	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,817	7,817	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)	\$ 7,817	\$ 7,817	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 109,010	\$ 109,010	46
47	TOTAL EQUITY(page 18, line 24)	\$ 850,550	\$ 850,550	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 959,560	\$ 959,560	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,156,193	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,156,193	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(305,643)	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	()	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)	\$ (305,643)	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)	\$ 850,550	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **SCOTT COUNTY NURSING CENTER**# **0004234**Report Period Beginning: **12/1/2010**Ending: **11/30/2011**

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.

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,066,158	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,066,158	3
	B. Ancillary Revenue		
4	Day Care	87	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 87	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		13
14	Non-Patient Meals	457	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	1,348	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,805	23
	D. Non-Operating Revenue		
24	Contributions	9,531	24
25	Interest and Other Investment Income***	9,347	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,878	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	INSURANCE REIMBURSEMENT FOR HAIL DAMAGE	27,375	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,375	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,114,303	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	615,375	31
32	Health Care	1,477,458	32
33	General Administration	248,728	33
	B. Capital Expense		
34	Ownership	51,557	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	26,828	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,419,946	40
41	Income before Income Taxes (line 30 minus line 40)**	(305,643)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (305,643)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** 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	1,778	2,063	\$ 48,165	\$ 23.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,211	5,673	118,721	20.93	3
4	Licensed Practical Nurses	13,918	15,826	283,440	17.91	4
5	CNAs & Orderlies	38,887	43,843	429,865	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,782	5,466	56,927	10.41	8
9	Activity Director	1,843	2,080	25,709	12.36	9
10	Activity Assistants	2,588	2,846	25,531	8.97	10
11	Social Service Workers	1,773	2,080	24,066	11.57	11
12	Dietician					12
13	Food Service Supervisor	2,097	2,484	34,002	13.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,071	13,903	130,771	9.41	15
16	Dishwashers					16
17	Maintenance Workers	1,969	2,122	23,468	11.06	17
18	Housekeepers	8,182	9,506	85,627	9.01	18
19	Laundry	1,894	2,076	21,589	10.40	19
20	Administrator	1,838	2,080	52,790	25.38	20
21	Assistant Administrator	687	687	5,669	8.25	21
22	Other Administrative					22
23	Office Manager	1,943	2,495	39,306	15.75	23
24	Clerical					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	1,863	2,093	23,220	11.09	31
32	Other Health Care(specify)					32
33	Other(specify)	1,771	2,080	41,392	19.90	33
34	TOTAL (lines 1 - 33)	105,095	119,403	\$ 1,470,258 *	\$ 12.31	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	96	\$ 4,320		35
36	Medical Director	12	8,625		36
37	Medical Records Consultant	12	75		37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,998		39
40	Physical Therapy Consultant	53	108,533		40
41	Occupational Therapy Consultant	41	51,133		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	2,207		43
44	Activity Consultant	12	823		44
45	Social Service Consultant				45
46	Other(specify)				46
47	LAB CONSULTANT	12	125		47
48	MEDICARE CONSULTANT	12	6,323		48
49	TOTAL (lines 35 - 48)	347	\$ 185,162		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.

ILLINOIS COUNTY NURSING HOME ASSOC
- (3)

Did the nursing home make political contributions or payments to a political action organization?

NO

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

N/A
- (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?

10
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

30,056

Line

10
- (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.

N/A
- (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)?

YES

NO

X

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.

\$

26,828

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?

N/A
- (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?

YES

Indicate the amount.

\$

457
- (16)

Travel and Transportation

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

NO

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.

\$

N/A

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

100

d. Have vehicle usage logs been maintained?

YES

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

YES

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

N/A

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

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name:

ZUMBAHLEN, EYTH, SURRATT, FOOTE & FLYNN, LTD.
- (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?

N/A

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