



Facility Name & ID Number Blackhawk Group Home

# 0034785 Report Period Beginning: 07/01/99 Ending: 06/30/00

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,490	6
7	15	TOTALS	15	5,490	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,459			5,459	13
14	TOTALS	5,459			5,459	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.44%

D. How many bed-hold days during this year were paid by Public Aid? 31 (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)  
\_\_\_\_\_

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 06/30/89

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/30/89 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/00 Fiscal Year: 06/30/00

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

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

Blackhawk Group Home

# 0034785

Report Period Beginning:

7/1/1999

Ending:

6/30/2000

## 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	34,921		720	35,641		35,641	35,641			1
2	Food Purchase		27,648		27,648		27,648	27,648			2
3	Housekeeping	19,228	5,092		24,320		24,320	24,320			3
4	Laundry	6,409			6,409		6,409	6,409			4
5	Heat and Other Utilities			13,500	13,500		13,500	13,500			5
6	Maintenance	15,772	5,836	1,540	23,148		23,148	23,148			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	76,330	38,576	15,760	130,666		130,666	130,666			8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	133,618	4,654	2,747	141,019		141,019	141,019			10
10a	Therapy			35	35		35	35			10a
11	Activities	9,131	4,499	60	13,690		13,690	13,690			11
12	Social Services	3,371		66	3,437		3,437	3,437			12
13	Nurse Aide Training	9,609			9,609		9,609	9,609			13
14	Program Transportation			5,175	5,175		5,175	5,175			14
15	Other (specify):*	3,234	183		3,417		3,417	3,417			15
16	<b>TOTAL Health Care and Programs</b>	158,963	9,336	8,083	176,382		176,382	176,382			16
	<b>C. General Administration</b>										
17	Administrative	42,806		66,257	109,063		109,063	109,063			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			4,012	4,012		4,012	4,012			20
21	Clerical & General Office Expenses	1,948	3,560	2,672	8,180		8,180	8,180			21
22	Employee Benefits & Payroll Taxes			72,008	72,008		72,008	72,008			22
23	Inservice Training & Education			3,205	3,205		3,205	3,205			23
24	Travel and Seminar			1,847	1,847		1,847	1,847			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,819	3,819		3,819	3,819			26
27	Other (specify):*			58	58		58	58			27
28	<b>TOTAL General Administration</b>	44,754	3,560	153,878	202,192		202,192	202,192			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	280,047	51,472	177,721	509,240		509,240	509,240			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.

Facility Name &amp; ID Number

Blackhawk Group Home

0034785

Report Period Beginning:

7/1/1999

Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			22,422	22,422		22,422		22,422			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,520	20,520		20,520		20,520			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			4,196	4,196		4,196		4,196			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			47,138	47,138		47,138		47,138			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			35,684	35,684		35,684		35,684			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			35,684	35,684		35,684		35,684			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	280,047	51,472	260,543	592,062		592,062		592,062			45

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

Facility Name & ID Number **Blackhawk Group Home**

# **0034785**

Report Period Beginning: **07/01/99**

Ending: **06/30/00**

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				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	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

OHF 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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Blackhawk Group Home

ID# 0034785

Report Period Beginning: 07/01/99

Ending: 06/30/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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
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31			31
32			32
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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			49
50			50
51			51
52			52
53			53
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58			58
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66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90





Facility Name & ID Number **Blackhawk Group Home**# **0034785**Report Period Beginning: **07/01/99**Ending: **06/30/00**

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kreider Services, Inc.	100	Pine Acres Group Home	Dixon			
Kreider Services, Inc.	100	Ashton Terrace Group Home	Ashton			
Kreider Services, Inc.	100	Amboy Terrace Group Home	Amboy			
Kreider Services, Inc.	100	Boyd, Division, Wasson Group Home	Amboy			
Kreider Services, Inc.	100	Franklin Grove, Ottawa, First S. Group Home	Franklin Grove, Dixon, Ashton			
Kreider Services, Inc.	100	New Main Group Home	Dixon			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number      **Blackhawk Group Home**      #      **0034785**      Report Period Beginning:      **07/01/99**      Ending:      **06/30/00**

## 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								<b>TOTAL</b>	\$	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 Blackhawk Group Home # 0034785 Report Period Beginning: 7/1/1999 Ending: 06/30/00

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

Name of Related Organization Kreider Services, Inc.  
 Street Address 500 Anchor Rd.  
 City / State / Zip Code Dixon, IL. 61021  
 Phone Number ( 815-288-6691  
 Fax Number ( 815-288-1636

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<a href="#">Ln 17, Col 3</a> Admin Salaries	# of clients		25	\$ 729,116	\$ 729,116		\$ 43,805	1
2	<a href="#">Ln 17, Col 3</a> Fringe Benefits	# of clients		25	130,086			7,814	2
3	<a href="#">Ln 17, Col 3</a> Utilities	Sq. Feet/ # of clients		25	4,750			286	3
4	<a href="#">Ln 17, Col 3</a> Maint./Rep. Bldg., grounds,equip	Sq. Feet/ # of clients		25	330			20	4
5	<a href="#">Ln 17, Col 3</a> Maint./Rep-Contractual	Sq. Feet/ # of clients		25	3,481			209	5
6	<a href="#">Ln 17, Col 3</a> Maint./Rep-Vehicle	# of clients		25	1,140			68	6
7	<a href="#">Ln 17, Col 3</a> Misc.	# of clients		25	1,249			75	7
8	<a href="#">Ln 17, Col 3</a> Legal Audit, Etc.	# of clients		25	94,739			5,693	8
9	<a href="#">Ln 17, Col 3</a> Dues & Membership	# of clients/ICFDD & DT		25	21,365			1,637	9
10	<a href="#">Ln 17, Col 3</a> Office Supplies, Postage	# of clients		25	31,033			1,865	10
11	<a href="#">Ln 17, Col 3</a> Telephone	# of clients		25	7,251			436	11
12	<a href="#">Ln 17, Col 3</a> Training	# of clients		25	7,842			471	12
13	<a href="#">Ln 17, Col 3</a> Travel Costs	# of clients		25	5,475			329	13
14	<a href="#">Ln 17, Col 3</a> Insurance-Auto/Prop	# of clients		25	3,125			187	14
15	<a href="#">Ln 17, Col 3</a> Depreciation	# of clients		25	26,764			1,608	15
16	<a href="#">Ln 17, Col 3</a> Building Rent	# of clients		25	22,623			1,359	16
17	<a href="#">Ln 17, Col 3</a> Consulting Exp.-Other Prof.	# of clients		25	8,505			395	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,098,874	\$ 729,116		\$ 66,257	25

Facility Name & ID Number Blackhawk Group Home # 0034785 Report Period Beginning: 07/01/99 Ending: 06/30/00

## 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	Name of Lender	2		3	4	5	6		7	8	9	10						
			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			
		<b>A. Directly Facility Related</b>																	
		<b>Long-Term</b>																	
1		Bank One - Springfield		x	Mortgage	\$5,482.00	07/02/97	\$ 445,000	\$ 366,666	07/01/05	0.0553	\$ 18,715	1						
2		Bank One - Springfield		x	Bond Fee Issuance	-	-	16,354	9,345	-	-	2,336	2						
3													3						
4													4						
5													5						
		<b>Working Capital</b>																	
6													6						
7													7						
8													8						
9		<b>TOTAL Facility Related</b>				\$5,482.00		\$ 461,354	\$ 376,011			\$ 21,051	9						
		<b>B. Non-Facility Related*</b>																	
10													10						
11													11						
12													12						
13													13						
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15		<b>TOTALS (line 9+line14)</b>						\$ 461,354	\$ 376,011			\$ 21,051	15						

\* 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.)

Facility Name & ID Number **Blackhawk Group Home**# **0034785** Report Period Beginning: **07/01/99** Ending: **06/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	0	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.)	\$	0	2
3. Under or (over) accrual (line 2 minus line 1).	\$	0	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	0	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	0	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	0	8
	1996	0	9
	1997	0	10
	1998	0	11
	1999	0	12
	<b>FOR OFF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**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.**

Facility Name & ID Number Blackhawk Group Home# 0034785 Report Period Beginning:07/01/99 Ending:06/30/00

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,260 B. General Construction Type: Exterior Brick Frame Wood Sprinkled Number of Stories 1C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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	<u>Building</u>		<u>1988</u>	\$ <u>17,537</u>	<u>1</u>
2	<u>Land Improvement</u>		<u>1990</u>	<u>2,743</u>	<u>2</u>
3	<b>TOTALS</b>			\$ <b>20,280</b>	<b>3</b>

Facility Name & ID Number Blackhawk Group Home

# 0034785

Report Period Beginning:

07/01/99

Ending:

06/30/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	15		1989	1989	\$ 296,982	\$ 11,879	25	\$ 11,879	\$	\$ 129,803	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Sprinkler System		1991	1,878	75	25	75		676	9
10		Carpet throughout House		1998	4,503	901	5	901		1,351	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	<b>TOTAL (lines 4 thru 35)</b>				\$ 303,363	\$ 12,855		\$ 12,855	\$	\$ 131,830	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.

Facility Name & ID Number **Blackhawk Group Home**# **0034785**

Report Period Beginning:

**07/01/99**

Ending:

**06/30/00**

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 6,915	\$ 638	\$ 638	\$		\$ 2,377	37
38	Current Year Purchases							38
39	Fully Depreciated Assets	36,681					36,681	39
40								40
41	TOTALS	\$ 43,596	\$ 638	\$ 638	\$		\$ 39,058	41

## D. Vehicle Depreciation (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	
42	Residential Transport	1999 Dodge Van	1999	\$ 23,228	\$ 5,807	\$ 5,807	\$	4	\$ 6,775	42
43										43
44										44
45										45
46	TOTALS			\$ 23,228	\$ 5,807	\$ 5,807	\$		\$ 6,775	46

## E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 390,467	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 19,300	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 19,300	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 177,663	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Corporate Equipment	\$	\$ 1,762	\$	52
53	Corporate Vehicle		107		53
54	Corporate Leasehold		1,253		54
55					55
56					56
57	TOTALS	\$	\$ 3,122	\$	57

## G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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: n/a  
 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 Date of Lease	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	<b>TOTAL</b>				\$			7

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.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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: \$ n/a 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	<b>TOTAL</b>		\$	\$	21

\* 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.

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		3,203		3,203
4	Clinical Wages (b)		6,406		6,406
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$ 9,609	\$	\$ 9,609
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,609		

- (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 aide 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 aides.

**C. CONTRACTUAL INCOME**

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

\$ 0

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	11
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>11</b>

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Blackhawk Group Home**# **0034785**Report Period Beginning: **07/01/99**

Ending:

**06/30/00**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/00**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,075	\$ 4,304,132	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	86,727	1,044,632	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		39,519	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Due From Hud &amp; Water deposit</b>		90,440	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 87,802	\$ 5,478,723	10
<b>B. Long-Term Assets</b>				
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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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): <b>Deposit with NIA</b>		3,546	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 3,546	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 87,802	\$ 5,482,269	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 119,837	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,900	550,172	30
31	Accrued Taxes Payable (excluding real estate taxes)		8,027	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
<b>Other Current Liabilities(specify):</b>				
36	<b>See Attached List</b>	1,604	43,123	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 17,504	\$ 721,159	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<b>Due to Capital</b>		109,940	43
44	<b>Due From Op-General</b>	(360,214)		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (360,214)	\$ 109,940	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (342,710)	\$ 831,099	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 430,512	\$ 4,651,170	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 87,802	\$ 5,482,269	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>372,216</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>372,216</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>58,296</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>58,296</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>430,512</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number **Blackhawk Group Home**

# **0034785**

Report Period Beginning: **07/01/99**

Ending: **06/30/00**

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 629,183	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 629,183	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	3,510	10
11	Nurses Aide Training Reimbursements	6,111	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 9,621	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	500	24
25	Interest and Other Investment Income***	10,701	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,201	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc. Income</b>	65	28
28a	<b>QMRP Training Income</b>	288	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 353	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 650,358	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	130,666	31
32	Health Care	176,382	32
33	General Administration	202,192	33
<b>B. Capital Expense</b>			
34	Ownership	47,138	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	35,684	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 592,062	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	58,296	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 58,296	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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.

Facility Name & ID Number **Blackhawk Group Home**# **0034785**Report Period Beginning: **7/1/1999**Ending: **6/30/2000**

## 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			\$	\$	1
2					2
3	165	183	3,292	17.99	3
4	996	1,107	14,928	13.49	4
5					5
6					6
7					7
8					8
9					9
10	924	1,004	9,131	9.09	10
11	269	299	3,371	11.27	11
12					12
13	116	129	1,643	12.74	13
14	122	136	1,231	9.05	14
15	3,240	3,522	32,047	9.10	15
16					16
17	1,316	1,463	15,772	10.78	17
18	1,944	2,113	19,228	9.10	18
19	648	704	6,409	9.10	19
20					20
21	2,364	2,627	43,396	16.52	21
22					22
23					23
24	216	240	1,358	5.66	24
25					25
26					26
27					27
28	1,988	2,209	25,629	11.60	28
29					29
30	10,049	10,923	99,378	9.10	30
31					31
32	200	222	3,234	14.57	32
33					33
34	24,558	26,881	\$ 280,047 *	\$ 10.42	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35		\$ 720	Ln 1, Col 13	35
36				36
37				37
38				38
39		425	Ln 1, Col 13	39
40				40
41				41
42				42
43		35	Ln 1, Col 13	43
44		60	Ln 1, Col 13	44
45		66	Ln 1, Col 13	45
46		441	Ln 1, Col 13	46
47		986	Ln 1, Col 13	47
48		895	Ln 1, Col 13	48
49		\$ 3,628		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53

A. Administrative Salaries		Ownership	Amount
Name	Function	%	
Ron Heiderscheit	Manager		\$ 7,515
PatHoward/ChrisJoyce/JillBlackburn	Supervisor		35,291
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 42,806

B. Administrative - Other		Amount
Description		
Allocation of Management & General		\$ 66,257
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$ 66,257

C. Professional Services		
Vendor/Payee	Type	Amount
		\$
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 0

D. Employee Benefits and Payroll Taxes		Amount
Description		
Workers' Compensation Insurance		\$ 13,231
Unemployment Compensation Insurance		1,216
FICA Taxes		20,891
Employee Health Insurance		29,492
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		0
403B Pension Plan		4,163
Tuition Reimbursement		421
E.A.P.		37
Christmas Gift/ Party		1,468
Physical Exam		217
Accrued Vacation Pay		872
TOTAL (agree to Schedule V, line 22, col.8)		\$ 72,008

E. Schedule of Non-Cash Compensation Paid to Owners or Employees		
Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions		Amount
Description		
IDPH License Fee		\$
Advertising: Employee Recruitment		1,019
Health Care Worker Background Check (Indicate # of checks performed <u>5</u> )		54
Subscription		158
Dues		417
Misc. Fees		84
Vehicle License		24
Bond Fees		1,437
Allocation Fees (survey fee)		819
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,012

G. Schedule of Travel and Seminar**		Amount
Description		
Out-of-State Travel		\$
In-State Travel		1,847
Seminar Expense		
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,847

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number **Blackhawk Group Home**# **0034785**

Report Period Beginning:

**07/01/99**

Ending:

**06/30/00****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? no  
If YES, give association name and amount. -
- (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? -
- (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? -
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line -
- (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)? 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 of Public Aid during this cost report period. \$ 35,684  
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? \_\_\_\_\_ 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 of Public Aid, 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? n/a 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. \$ n/a 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? 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. \$ -
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- 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? 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?** yes  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Clifton Gunderson LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. It is not yet completed.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? n/a
- (19) If total legal fees are in excess of \$2500, 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.