

Facility Name & ID Number Eunice Smith Home

0008409 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	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
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	1,792	15,896	3,250	20,938	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,792	15,896	3,250	20,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.52%

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)

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 12/30/1966

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 34 and days of care provided 3,250

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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		241,032	82,461	323,493		323,493	343,668	667,161		1
2	Food Purchase										2
3	Housekeeping	126,493	18,885	8,584	153,962		153,962		153,962		3
4	Laundry		17,120	48,450	65,570		65,570		65,570		4
5	Heat and Other Utilities			90,446	90,446		90,446		90,446		5
6	Maintenance	43,934	1,746	41,538	87,218		87,218		87,218		6
7	Other (specify):* Cafeteria							71,583	71,583		7
8	TOTAL General Services	170,427	278,783	271,479	720,689		720,689	415,251	1,135,940		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,516,758	402,153	93,303	2,012,214		2,012,214	27,083	2,039,297		10
10a	Therapy		3,683	247,709	251,392		251,392		251,392		10a
11	Activities	132,472	1,931	9,027	143,430		143,430		143,430		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,649,230	407,767	354,839	2,411,836		2,411,836	27,083	2,438,919		16
	C. General Administration										
17	Administrative	143,923	15,155	213,135	372,213		372,213	76,601	448,814		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			4,833	4,833		4,833	(803)	4,030		20
21	Clerical & General Office Expenses							31,116	31,116		21
22	Employee Benefits & Payroll Taxes			603,296	603,296		603,296		603,296		22
23	Inservice Training & Education										23
24	Travel and Seminar			792	792		792		792		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			14,713	14,713		14,713		14,713		26
27	Other (specify):*										27
28	TOTAL General Administration	143,923	15,155	836,769	995,847		995,847	106,914	1,102,761		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,963,580	701,705	1,463,087	4,128,372		4,128,372	549,248	4,677,620		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 & ID Number Eunice Smith Home

#0008409

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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			65,321	65,321		65,321		65,321			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			15,499	15,499		15,499		15,499			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			80,820	80,820		80,820		80,820			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	15,595	722		16,317		16,317		16,317			39
40	Barber and Beauty Shops			10,255	10,255		10,255		10,255			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							33,945	33,945			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	15,595	722	10,255	26,572		26,572	33,945	60,517			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,979,175	702,427	1,554,162	4,235,764		4,235,764	583,193	4,818,957			45

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

Eunice Smith Home

ID# 0008409

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eunice Smith Home# 0008409

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	343,668	0	0	0	0	0	0	0	0	0	343,668	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	71,583	0	0	0	0	0	0	0	0	0	71,583	7
8	TOTAL General Services	0	415,251	0	415,251	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	27,083	0	0	0	0	0	0	0	0	0	27,083	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	27,083	0	27,083	16								
	C. General Administration													
17	Administrative	(8,278)	84,879	0	0	0	0	0	0	0	0	0	76,601	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(803)	0	0	0	0	0	0	0	0	0	0	(803)	20
21	Clerical & General Office Expenses	0	31,116	0	0	0	0	0	0	0	0	0	31,116	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(9,081)	115,995	0	106,914	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,081)	558,329	0	549,248	29								

STATE OF ILLINOIS

Facility Name & ID Number Eunice Smith Home# 0008409

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(9,081)	558,329	0	0	0	0	0	0	0	0	0	549,248	45

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
Alton Memorial Hospital	100%					
BJC Health Care	100%					

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 Dietary	\$ 323,493		100.00%	\$ 667,161	\$ 343,668	1
2	V	7 Cafeteria			100.00%	71,583	71,583	2
3	V	10 Medical Records			100.00%	27,083	27,083	3
4	V	21 Administrative and General			100.00%	31,116	31,116	4
5	V	17 Home Office Costs	156,547		100.00%	241,426	84,879	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		\$ 480,040			\$ 1,038,369	\$ * 558,329	14

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

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	Not Applicable								\$	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 Eunice Smith Home

0008409

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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	1	Dietary	Meals	179,471	6	\$ 1,967,660	\$ 60,852	\$ 667,161	1
2	7	Cafeteria	FTE's	59,745	33	757,075	5,649	71,583	2
3	10	Medical Recirds	Gross Revenue	352,502,412	25	1,713,774	5,570,569	27,083	3
4	21	Finance	Gross Revenue	352,502,412	25	1,652,184	5,570,569	26,109	4
5	21	A&G	Accumulated Cost	75,926,136	43	14,561,895	26,109	5,007	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					\$ 20,652,588	\$	\$ 796,943	25

Facility Name & ID Number

Eunice Smith Home

0008409

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		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						\$	\$			\$								
2			Not Applicable															
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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

1. Real Estate Tax accrual used on 2008 report.		\$	7,719	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.)		\$	16,731	2
3. Under or (over) accrual (line 2 minus line 1).		\$	9,012	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	6,487	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.		\$	15,499	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	15,150	8	
	2005	15,653	9	
	2006	15,493	10	
	2007	16,187	11	
	2008	16,137	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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 Eunice Smith Home

0008409

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,604 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			1937	\$ 21,169	1
2					2
3	TOTALS			\$ 21,169	3

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1966	1966	\$ 433,793	\$	40	\$	\$	\$ 433,793	4
5			1968	1968	1,770		Various			1,770	5
6			1968	1968	762		Various			762	6
7			1973	1973	1,000		33			1,000	7
8			1980	1980	1,178		Various			1,178	8
	Improvement Type**										
9	A/C Units		1995		222		5			222	9
10	7/1/2 Ton		1981		6,888		20			6,888	10
11	Water Heater		1981		16,430		15			16,430	11
12	Sprinkler		1981		1,980		25			1,980	12
13	Painting		1985		13,850		Various			13,850	13
14	Misc Renovation		1988		75,082		15			75,082	14
15	Misc Renovation		1992		4,155	203	20	203		4,155	15
16	A/C Units		1989		16,438		15			16,438	16
17	Misc Renovation		1990		53,990		Various			53,990	17
18	Plumbing		1966		521,325		Various			521,325	18
19	Incinerator Upgrade		1973		695		5			695	19
20	Misc		1968		790		Various			790	20
21	Misc		1970		190		10			190	21
22	Incinerator Upgrade		1967		3,825		20			3,825	22
23	Parking/Wheelchair		1983		40,133		12			40,133	23
24	Driveway		1989		4,900		10			4,900	24
25	Driveway		1995		8,972	600	15	600		8,972	25
26	Fence Extension		1990		698		15			698	26
27	Parkin/Walk/Curbs		1966		47,660		Various			47,660	27
28	Misc Landscaping		1968		330		Various			330	28
29	Misc Landscaping		1970		600		Various			600	29
30	Oil & Chip Roadway		1981		3,805		5			3,805	30
31	Wall Construction		1991		5,509	275	20	275		5,363	31
32	Door Frame		1991		1,770		10			1,770	32
33	Concrete		1992		726		15			726	33
34	Patch & Seal Parking		1994		7,435		12			7,435	34
35	Door Frame		1995		1,449		10			1,449	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

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Install Water Softener	1995	\$ 14,149	\$	10	\$	\$	\$ 14,149	37
38	Window Treatment Lobby	1995	2,138		10			2,138	38
39	East Dining Room Carpet	1995	2,844		5			2,844	39
40	East Dining Room Alum Door	1995	1,449	72	20	72		1,044	40
41	East Dining Room Wall Covering	1995	2,845		5			2,845	41
42	Landscape	1995	42,800	2,853	15	2,853		41,369	42
43	Conference Room Renovation	1996	7,916		10			7,916	43
44	Replace Secondary Signage	1997	9,471		10			9,471	44
45	Install Vinyl Flooring Rest Rooms	1997	32,700		10			32,700	45
46	Elevator Door Protection	1997	1,656		10			1,656	46
47									47
48	Cabinetry	1997	5,816	291	20	291		6,107	48
49									49
50	Door Frame Protectors	1997	2,426		10			2,426	50
51	Interior & Exterior Lighting	1997	20,084		10			20,084	51
52	Install Vinyl Flooring Rest Rooms	1997	29,773		10			29,773	52
53	Replace Carpet East Dining Room	1998	7,927		5			7,927	53
54	Install New Transformer	1998	28,092	1,405	20	1,405		16,157	54
55	Storm Drain Back Parking Lot	1999	8,413	467	18	467		4,904	55
56	Install 4 Smoke Dampers in Basement	1999	6,248	417	15	417		4,378	56
57	Install Wandeguard Locking System	1999	2,162		7			2,162	57
58	Wall Covering & Paint	2001	8,106		5			8,106	58
59	Fire Sprinkler System	2001	193,922	7,757	25	7,757		67,227	59
60	Roof Replacement	2003	31,668	3,167	10	3,167		22,171	60
61	Air Conditioning System	2003	75,514		5			75,514	61
62	Security Camera Upgrade	2003	4,737		5			4,737	62
63	Wandeguard Door Alarm	2003	28,750	2,875	10	2,875		17,969	63
64	Air Conditioning System	2003	54,665		5			54,665	64
65	Wood Fencing Courtyard	2004	21,760	2,720	8	2,720		14,507	65
66	Landscaping	2004	21,759	2,176	10	2,176		13,056	66
67	Carpentry Work Alzheimer's Unit	2004	44,130	2,942	15	2,942		17,407	67
68	Carpentry Work Tub Room Conversion	2004	11,500	767	15	767		4,154	68
69	Carpentry Work Screen Patio West Wing	2004	19,200	1,280	15	1,280		6,613	69
70	TOTAL (lines 4 thru 69)		\$ 2,022,970	\$ 30,267		\$ 30,267	\$	\$ 1,794,380	70

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

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,022,970	\$ 30,267		\$ 30,267	\$	\$ 1,794,380	1
2	Metal or Wood Cabinets	2004	26,500	1,767	15	1,767		9,571	2
3	Commercial Water Heater	2004	44,917	4,492	10	4,492		24,379	3
4	Extend Floor Structure, Install Fire Dampers	2005	31,438	2,096	15	2,096		9,781	4
5	Floor Finishes- Carpet	2005	3,621	722	5	722		3,621	5
6	Fire Protection Sprinkler System	2005	3,650	146	25	146		681	6
7	Gazebo	2007	5,097	510	10	510		1,496	7
8	Automatic Front Door and Frame	2007	7,059	1,412	5	1,412		3,059	8
9	Wood Trim and Aluminum	2008	35,700	7,140	5	7,140		8,330	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	TOTAL (lines 1 thru 33)		\$ 2,180,952	\$ 48,552		\$ 48,552	\$	\$ 1,855,298	34

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

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	
71	Purchased in Prior Years	\$ 344,228	\$ 16,448	\$ 16,448			\$ 262,307	71
72	Current Year Purchases	3,852	321	321			321	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 348,080	\$ 16,769	\$ 16,769			\$ 262,628	75

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	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,550,201	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,321	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,321	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)	\$ 2,117,926	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.

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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:	<u>Not Applicable</u>			\$ _____			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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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)	\$			

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	

- (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.)

	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	\$		\$ 115,670	\$		\$ 115,670	1
2	Licensed Speech and Language Development Therapist		hrs			11,871			11,871	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			120,168			120,168	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$ 247,709	\$		\$ 247,709	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.

Facility Name & ID Number **Eunice Smith Home**# **0008409**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 1,202,308	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		14,151,745	3
4	Supply Inventory (priced at)		1,221,675	4
5	Short-Term Investments			5
6	Prepaid Insurance		64,740	6
7	Other Prepaid Expenses		196,005	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		679,356	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 17,515,829	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		183,572	13
14	Buildings, at Historical Cost		121,353,189	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		32,810,382	16
17	Accumulated Depreciation (book methods)		(81,096,498)	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):		127,985,421	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 201,236,066	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 218,751,895	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 2,754,562	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		889,122	29
30	Accrued Salaries Payable		6,260,636	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	Other Current Liabilities		14,168,434	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 24,072,754	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		19,274,356	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Other Long Term Liab		811,676	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 20,086,032	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 44,158,786	46
47	TOTAL EQUITY(page 18, line 24)	\$ 174,593,109	\$ 174,593,109	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 174,593,109	\$ 218,751,895	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 144,084,355	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 144,084,355	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	312,164	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) AMH Net Income	29,952,991	15
16	Other (describe) Adjustment	243,599	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 30,508,754	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)	\$ 174,593,109	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eunice Smith Home# 0008409Report Period Beginning: 01/01/2009Ending: 12/31/2009

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	\$ 5,578,125	1
2	Discounts and Allowances for all Levels	(1,037,954)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,540,171	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	9,355	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,355	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	1,485	28
28a	Misc Non Op Income	(3,083)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,598)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,547,928	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	720,689	31
32	Health Care	2,411,836	32
33	General Administration	995,847	33
B. Capital Expense			
34	Ownership	80,820	34
C. Ancillary Expense			
35	Special Cost Centers	26,572	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,235,764	40
41	Income before Income Taxes (line 30 minus line 40)**	312,164	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 312,164	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 Eunice Smith Home

0008409

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	1,680	1,936	\$ 59,886	\$ 30.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,523	8,683	240,323	27.68	3
4	Licensed Practical Nurses	20,356	23,982	484,392	20.20	4
5	CNAs & Orderlies	48,644	55,177	732,157	13.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	7,515	8,433	132,472	15.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,039	2,300	43,934	19.10	17
18	Housekeepers	10,078	11,366	126,493	11.13	18
19	Laundry					19
20	Administrator	1,835	1,968	79,436	40.36	20
21	Assistant Administrator					21
22	Other Administrative	2,485	3,350	64,487	19.25	22
23	Office Manager					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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pharmacy</u>	260	288	15,595	54.15	33
34	TOTAL (lines 1 - 33)	102,415	117,483	\$ 1,979,175 *	\$ 16.85	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	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		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

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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. 3,675 Life Services Network
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,732 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. _____
- (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. \$ 33,945
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? No 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? No
d. Have vehicle usage logs been maintained? NA
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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? NA
Attach invoices and a summary of services for all architect and appraisal fees.