

Facility Name & ID Number Hamilton Memorial Nursing Center

8000796 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	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 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,981	6,017		18,998	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,981	6,017		18,998	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.75%

D. How many bed-hold days during this year were paid by the Department? 263 (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)
NONE

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 1970

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 _____ 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: _____ Fiscal Year: _____

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

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	217,861	27,202	651	245,714		245,714		245,714		1
2	Food Purchase		85,278		85,278		85,278	(1,122)	84,156		2
3	Housekeeping	86,399	11,719		98,118		98,118		98,118		3
4	Laundry		127,097		127,097		127,097	25,798	152,895		4
5	Heat and Other Utilities			69,798	69,798		69,798		69,798		5
6	Maintenance	19,325	2,529	11,282	33,136		33,136		33,136		6
7	Other (specify):*										7
8	TOTAL General Services	323,585	253,825	81,731	659,141		659,141	24,676	683,817		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	844,508	32,439	3,923	880,870		880,870	(14)	880,856		10
10a	Therapy										10a
11	Activities	35,416	1,818	147	37,381		37,381		37,381		11
12	Social Services	23,784	212	2,205	26,201		26,201		26,201		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	903,708	34,469	6,275	944,452		944,452	(14)	944,438		16
	C. General Administration										
17	Administrative	58,282	3,087	9,008	70,377	(2,953)	67,424	162,490	229,914		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses					2,953	2,953	7,367	10,320		21
22	Employee Benefits & Payroll Taxes			296,285	296,285		296,285	95,446	391,731		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			23,464	23,464		23,464		23,464		26
27	Other (specify):*										27
28	TOTAL General Administration	58,282	3,087	328,757	390,126		390,126	265,303	655,429		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,285,575	291,381	416,763	1,993,719		1,993,719	289,965	2,283,684		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			76,212	76,212		76,212		76,212			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			76,212	76,212		76,212		76,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			5,778	5,778		5,778		5,778			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							32,850	32,850			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			5,778	5,778		5,778	32,850	38,628			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,285,575	291,381	498,753	2,075,709		2,075,709	322,815	2,398,524			45

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

Hamilton Memorial Nursing Center

ID# 8000796

Report Period Beginning: 7/1/08

Ending: 6/30/09

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 Hamilton Memorial Nursing Center# 8000796

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	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	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	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	(14)	0	0	0	0	0	0	0	0	0	0	(14)	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	(14)	0	0	0	0	0	0	0	0	0	0	(14)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,631)	0	0	0	0	0	0	0	0	0	0	(1,631)	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	(1,631)	0	0	0	0	0	0	0	0	0	0	(1,631)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,767)	0	0	0	0	0	0	0	0	0	0	(2,767)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hamilton Memorial Nursing Center# 8000796

Report Period Beginning:

7/1/08

Ending:

6/30/09

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)	(2,767)	0	0	0	0	0	0	0	0	0	0	(2,767)	45

Facility Name & ID Number

Hamilton Memorial Nursing Center

8000796

Report Period Beginning:

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Ending:

6/30/09

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
Hamilton Memorial Hospital District	100%			Hamilton Memorial H	McLeansboro	Hospital
				Hamilton Memorial H	McLeansboro	Home Health Agency

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		\$	Hamilton Memorial Hospital District	N/A	\$	\$	1
2	V			Hamilton Memorial Hospital HHA	N/A			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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	N/A								\$	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 Hamilton Memorial Nursing Center

8000796

Report Period Beginning:

7/1/08

Ending: 6/30/09

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

Hamilton Memorial Hospital

Street Address

611 S. Marshall P.O. Box 429

City / State / Zip Code

McLeansboro, IL 62859

Phone Number

(618) 643-2361

Fax Number

(618) 643-2875

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	4	Laundry	Pounds of Laundry		\$	\$		25,798	1
2	17	Administration	Accumulated Costs					162,490	2
3	21	Phone Expense	Number of Phones					3,555	3
4	21	Purchases	Supply Costs					5,443	4
5	22	Employee Benefits	Gross Salaries					95,446	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				\$	\$		292,732	25

Facility Name & ID Number

Hamilton Memorial Nursing Center

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7/1/08

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6/30/09

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	N/A					\$	\$			\$	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

1. Real Estate Tax accrual used on 2008 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 2009 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:	2004	_____	8
	2005	_____	9
	2006	_____	10
	2007	_____	11
	2008	_____	12
	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 Hamilton Memorial Nursing Center

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,358 B. General Construction Type: Exterior Brick Frame _____ 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).

Hamilton Memorial Hospital District
Hospital
Sq. Feet 62,556
25 Beds

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		<u>17,402</u>	<u>1959</u>	<u>\$ 4,690</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>17,402</u>		<u>\$ 4,690</u>	<u>3</u>

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	60		1970	1970	\$ 258,985	\$ 6,467	40	\$ 6,467		\$ 253,297	4
5			1970	1970	94,949		20			94,949	5
6											6
7											7
8											8
	Improvement Type**										
9			1970		6,888		20			6,888	9
10			1971		2,554		15			2,554	10
11			1974		72		20			72	11
12			1975		764		20			764	12
13			1977		10,178		10			10,178	13
14			1983		2,798		20			2,798	14
15			1984		2,312		15			2,312	15
16			1989		3,216		10			3,216	16
17			1990		2,231		5			2,231	17
18			1991		2,400		15			2,400	18
19			1991		1,166		10			1,166	19
20			1991		2,892		5			2,892	20
21			1991		13,242		10			13,242	21
22			1991		7,500		5			7,500	22
23			1992		384		5			384	23
24			1992		1,317		10			1,317	24
25			1993		1,466		5			1,466	25
26			1996		1,920		5			1,920	26
27			1996		960	64	15	64		864	27
28			1997		3,506		10			3,506	28
29			1997		3,491	233	15	233		2,910	29
30			1998		1,085		5			1,085	30
31			1998		2,385		10			2,385	31
32			1998		1,206		10			1,206	32
33			1998		2,471		10			2,471	33
34			1999		35,462	2,364	15	2,364		24,823	34
35			1999		1,986		8			1,986	35
36			1999		961		5			961	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 Hamilton Memorial Nursing Center

8000796

Report Period Beginning:

7/1/08

Ending:

6/30/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1999	\$ 747	\$ 36	10	\$ 36		\$ 747	37
38	1999	600	30	10	30		600	38
39	1999	1,917		5			1,917	39
40	1999	500		5			500	40
41	1999	4,706	314	15	314		2,982	41
42	2000	11,161	744	15	744		6,324	42
43	2000	1,111	74	15	74		629	43
44	2001	15,100	1,510	10	1,510		11,325	44
45	2002	5,450	545	10	545		4,088	45
46	2002	3,188	319	10	319		2,072	46
47	2002	749	75	10	75		487	47
48	2002	2,481	248	10	248		1,612	48
49	2002	17,218	1,148	15	1,148		7,462	49
50	2003	8,809	587	15	587		3,816	50
51	2004	1,943	194	10	194		1,068	51
52	2004	1,220	122	10	122		671	52
53	2004	6,172	309	20	309		1,699	53
54	2004	5,600	560	10	560		3,080	54
55	2004	22,802	2,280	10	2,280		12,541	55
56	2004	1,798	180	10	180		989	56
57	2004	5,210	347	15	347		1,563	57
58	2004	21,882	1,459	15	1,459		6,565	58
59	2004	5,503	550	10	550		2,475	59
60	2005	30,813	2,008	15	2,008		9,036	60
61	2005	7,400	370	20	370		1,665	61
62	2006	3,000	200	15	200		700	62
63	2006	41,167	2,744	15	2,744		9,605	63
64	2006	69,900	2,796	25	2,796		9,786	64
65	2006	6,580	439	15	439		1,536	65
66	2006	3,233	162	20	162		566	66
67	2008	1,181	118	10	118		413	67
68	2006	2,500	167	15	167		584	68
69	2008	4,990	499	10	499		749	69
70		\$ 787,378	\$ 30,262		\$ 30,262		\$ 563,595	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	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		\$ 787,378	\$ 30,262		\$ 30,262		\$ 563,595	1
2	2009	16,070	536	15	536		536	2
3	2009	731,418	18,285	20	18,285		18,285	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		\$ 1,534,866	\$ 49,083		\$ 49,083		\$ 582,416	34

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

Facility Name & ID Number **Hamilton Memorial Nursing Center**

8000796

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	\$ 336,607	\$ 14,329	\$ 14,329	\$		\$ 268,878	71
72	Current Year Purchases	258,545	12,798	12,798			12,798	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 595,152	\$ 27,127	\$ 27,127	\$		\$ 281,676	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)	\$ 2,134,708	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 76,210	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,210	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)	\$ 864,092	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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 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. _____ /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	\$		\$	\$		\$	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 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			\$		\$	\$		\$	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 **Hamilton Memorial Nursing Center**

8000796

Report Period Beginning: **7/1/08**

Ending: **6/30/09**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/09** (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	\$ 9,629	\$ 2,541,861	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,956,921	3
4	Supply Inventory (priced at)	14,054	425,566	4
5	Short-Term Investments			5
6	Prepaid Insurance		184,215	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Third Party Reimbursement		300,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 23,683	\$ 5,408,563	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,690	74,449	13
14	Buildings, at Historical Cost	1,534,866	11,911,509	14
15	Leasehold Improvements, at Historical Cost		607,332	15
16	Equipment, at Historical Cost	595,152	5,323,969	16
17	Accumulated Depreciation (book methods)	(864,092)	(7,360,143)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		6,746,429	21
22	Other Long-Term Assets (specify):		6,463,049	22
23	Other(specify): Unamortized Bond Cost		573,453	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,270,616	\$ 24,340,047	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,294,299	\$ 29,748,610	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 1,408,452	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		458,198	29
30	Accrued Salaries Payable		690,449	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	Est Third Party Liability		128,080	36
37	Other		2,723	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 2,687,902	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		18,368,031	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Interest Rate Swap Contract		2,304,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 20,672,031	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 23,359,933	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,294,299	\$ 6,388,677	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,294,299	\$ 29,748,610	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 363,984	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 363,984	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(218,594)	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)	1,148,909	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 930,315	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)	\$ 1,294,299	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Hamilton Memorial Nursing Center**# **8000796**Report Period Beginning: **7/1/08**Ending: **6/30/09**

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	\$ 1,746,948	1
2	Discounts and Allowances for all Levels	(53,441)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,693,507	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	6,304	13
14	Non-Patient Meals	1,122	14
15	Telephone, Television and Radio	1,631	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	14	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)	\$ 9,071	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,065	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,065	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Tax Revenue	151,472	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 151,472	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,857,115	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	659,141	31
32	Health Care	944,452	32
33	General Administration	390,126	33
B. Capital Expense			
34	Ownership	76,212	34
C. Ancillary Expense			
35	Special Cost Centers	5,778	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)*	\$ 2,075,709	40
41	Income before Income Taxes (line 30 minus line 40)**	(218,594)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (218,594)	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.

Facility Name & ID Number **Hamilton Memorial Nursing Center**

8000796

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	3,698	4,051	\$ 95,520	\$ 23.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	421	461	8,472	18.38	3
4	Licensed Practical Nurses	17,353	19,835	299,020	15.08	4
5	CNAs & Orderlies	39,665	44,534	441,496	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,431	3,902	35,416	9.08	10
11	Social Service Workers	1,820	2,012	23,784	11.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,788	23,184	217,861	9.40	15
16	Dishwashers					16
17	Maintenance Workers	1,670	1,954	19,325	9.89	17
18	Housekeepers	8,732	9,933	86,399	8.70	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,080	3,658	58,282	15.93	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)					33
34	TOTAL (lines 1 - 33)	100,658	113,524	\$ 1,285,575 *	\$ 11.32	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 Hamilton Memorial Nursing Center# 8000796Report Period Beginning: 7/1/08Ending: 6/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES except RN
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. \$ 32,850
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. \$ N/A Has any meal income been offset against related costs? _____ 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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Kerber, Eck & Braeckel LLP
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.