

Facility Name & ID Number Home Bridge Center

0050153 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	<u>31</u>	Skilled (SNF)	<u>31</u>	<u>11,315</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>49</u>	Intermediate (ICF)	<u>49</u>	<u>17,885</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	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	4 Private Pay	Other	Total	
8	SNF		<u>2,329</u>	<u>2,515</u>	<u>4,844</u>	8
9	SNF/PED					9
10	ICF	<u>10,070</u>			<u>10,070</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,070</u>	<u>2,329</u>	<u>2,515</u>	<u>14,914</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.08%

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)
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 05/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/08 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 31 and days of care provided 2,515

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Home Bridge Center # 0050153 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	153,957	6,519	6,895	167,371		167,371		167,371		1
2	Food Purchase		110,059		110,059		110,059		110,059		2
3	Housekeeping	154,439	23,752	3,805	181,996		181,996		181,996		3
4	Laundry		5,407	570	5,977		5,977		5,977		4
5	Heat and Other Utilities			84,229	84,229		84,229	(8,795)	75,434		5
6	Maintenance			37,538	37,538		37,538		37,538		6
7	Other (specify):*										7
8	TOTAL General Services	308,396	145,737	133,037	587,170		587,170	(8,795)	578,375		8
	B. Health Care and Programs										
9	Medical Director			29,157	29,157		29,157		29,157		9
10	Nursing and Medical Records	1,079,263	122,746	59,169	1,261,178		1,261,178		1,261,178		10
10a	Therapy										10a
11	Activities	81,869	733	1,198	83,800		83,800		83,800		11
12	Social Services			9	9		9		9		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,161,132	123,479	89,533	1,374,144		1,374,144		1,374,144		16
	C. General Administration										
17	Administrative	161,557			161,557		161,557		161,557		17
18	Directors Fees										18
19	Professional Services			6,490	6,490		6,490		6,490		19
20	Dues, Fees, Subscriptions & Promotions			13,401	13,401		13,401	(10,834)	2,567		20
21	Clerical & General Office Expenses	104,692	7,128	48,219	160,039		160,039		160,039		21
22	Employee Benefits & Payroll Taxes			262,537	262,537		262,537		262,537		22
23	Inservice Training & Education			399	399		399		399		23
24	Travel and Seminar			1,447	1,447		1,447		1,447		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,100	65,100		65,100		65,100		26
27	Other (specify):*			7,031	7,031		7,031	(7,031)			27
28	TOTAL General Administration	266,249	7,128	404,624	678,001		678,001	(17,865)	660,136		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,735,777	276,344	627,194	2,639,315		2,639,315	(26,660)	2,612,655		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			22,972	22,972		22,972	92,453	115,425			30
31	Amortization of Pre-Op. & Org.			2,123	2,123		2,123		2,123			31
32	Interest			84,989	84,989		84,989	192,000	276,989			32
33	Real Estate Taxes			24,000	24,000		24,000		24,000			33
34	Rent-Facility & Grounds			192,000	192,000		192,000	(192,000)				34
35	Rent-Equipment & Vehicles			7,830	7,830		7,830		7,830			35
36	Other (specify):*											36
37	TOTAL Ownership			333,914	333,914		333,914	92,453	426,367			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			368,565	368,565		368,565		368,565			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,243	45,243		45,243		45,243			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			413,808	413,808		413,808		413,808			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,735,777	276,344	1,374,916	3,387,037		3,387,037	65,793	3,452,830			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,795)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,089)	30		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	(7,031)	27		24
25	Fund Raising, Advertising and Promotional	(10,834)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,749)		\$	30

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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (45,749)		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	Outpatient Services		X	5,715	39	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs		X	158,717	39	43
44	Illinois Bed Tax		X	45,243	42	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 209,675		47

BHF USE ONLY

48		49		50		51		52	
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Home Bridge Center

ID# 0050153

Report Period Beginning: 01/01/09

Ending: 12/31/09

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 Home Bridge Center

0050153

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	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	(8,795)	0	0	0	0	0	0	0	0	0	0	(8,795)	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	(8,795)	0	(8,795)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	(10,834)	0	0	0	0	0	0	0	0	0	0	(10,834)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(7,031)	0	0	0	0	0	0	0	0	0	0	(7,031)	27
28	TOTAL General Administration	(17,865)	0	(17,865)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,660)	0	(26,660)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Home Bridge Center# 0050153

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(19,089)	111,542	0	0	0	0	0	0	0	0	0	92,453	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	192,000	0	0	0	0	0	0	0	0	0	192,000	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(192,000)	0	0	0	0	0	0	0	0	0	(192,000)	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	(19,089)	111,542	0	92,453	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)	(45,749)	111,542	0	0	0	0	0	0	0	0	0	65,793	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
James M. Palazzo	50.0	East Bank Center	Loves Park	Advanced Therapy Sol	Rockford	Therapy
Uptal Parekh	50.0			Pearl Center LLC	Belvidere	Real Estate
				Transitions Hospice LI	Rockford	Hospice

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	34 Rent	\$ 192,000	Pearl Center LLC		\$	(192,000)	1
2	V	32 Interest Expense		Pearl Center LLC		192,000	192,000	2
3	V	30 Depreciation		Pearl Center LLC		111,542	111,542	3
4	V							4
5	V	39 Therapy	193,534	Advanced Therapy Solutions LLC		193,534		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		\$ 385,534			\$ 497,076	\$ * 111,542	14

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

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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	Sonali Parekh	Consultant	Admin	0.00	0	10	25.00	wages	\$ 8,736	17-1	1
2	James Palazzo	Manager	Admin	50.00	0	10	25.00	wages	21,154	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 29,890		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 Home Bridge Center

0050153

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Home Bridge Center

0050153

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	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			
A. Directly Facility Related																			
Long-Term																			
1	Sonali Parekh	X		Start up funding	None	2008	\$ 308,000	\$ 308,000	None	7.0000	\$ 21,300	1							
2	Prior Owner		X	Mortgage Financing	\$16,000.00	7/1/08	2,000,000	2,000,000	2011	7.7500	155,000	2							
3	Prior Owner		X	Mortgage Financing	None	7/1/08	478,000	478,000	2011	7.7500	37,000	3							
4												4							
5												5							
Working Capital																			
6	Midwest Business Credit		X	Working Capital	Interest only	2009	375,000	373,990	2010	floating	63,689	6							
7												7							
8												8							
9	TOTAL Facility Related				\$16,000.00		\$ 3,161,000	\$ 3,159,990			\$ 276,989	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 3,161,000	\$ 3,159,990			\$ 276,989	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

Facility Name & ID Number Home Bridge Center

0050153 Report Period Beginning:

01/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,000 B. General Construction Type: Exterior Masonry 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).

None

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: 31,838 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 2,123 4. Dates Incurred: 2008

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Nursing Facility</u>	<u>100,000</u>	<u>2008</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	100,000		\$ 100,000	3

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	80	2008	1960	\$ 2,234,000	\$ 57,282	39	\$ 57,282	\$	\$ 83,536
5									
6									
7									
8									
	Improvement Type**								
9	Landscaping improvements	2008		7,460	727	15	497	(230)	914
10	Land Improvements - tree removal	2009		5,335	267	15	119	(148)	267
11									
12									
13	Walls and interior trim improvements	2008		25,974	2,532	15	1,732	(800)	3,182
14	Walls and interior trim improvement	2008		11,265	1,099	15	751	(348)	1,380
15	Patient room renovation, new flooring	2008		19,695	1,920	15	1,313	(607)	2,413
16	Remodeling of patient rooms - A, B, C wings	2008		26,904	2,623	15	1,793	(830)	3,296
17	Replaced plumbing	2008		2,672	261	15	178	(83)	327
18	Remodeling of therapy room, dining	2008		6,121	597	15	408	(189)	750
19	Fire sprinkler system improvements	2008		26,004	2,535	15	1,734	(801)	3,185
20									
21									
22	Walls and interior trim improvements	2009		1,943	97	15	129	32	97
23	Patient room renovation, new flooring	2009		25,527	1,277	15	1,560	283	1,277
24	Remodeling of patient rooms - C wing	2009		13,467	673	15	748	75	673
25	Remodeling of patient rooms - C wing, entrance ramp	2009		19,454	973	15	888	(85)	973
26	Generator pad and walks	2009		8,599	430	15	191	(239)	430
27	New flooring	2009		884	44	15	10	(34)	44
28									
29									
30									
31									
32									
33									
34									
35									
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 Home Bridge Center

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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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,435,304	\$ 73,337		\$ 69,333	\$ (4,004)	\$ 102,744	70

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

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Ending:

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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	\$ 193,217	\$ 51,123	\$ 38,643	\$ (12,480)	5	\$ 66,164	71
72	Current Year Purchases	49,048	7,165	5,750	(1,415)	5	7,165	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 242,265	\$ 58,288	\$ 44,393	\$ (13,895)		\$ 73,329	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	Utility	Ford F-150	2008	\$ 8,495	\$ 2,888	\$ 1,699	\$ (1,189)	5	\$ 3,595	76
77										77
78										78
79										79
80	TOTALS			\$ 8,495	\$ 2,888	\$ 1,699	\$ (1,189)		\$ 3,595	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)	\$ 2,786,064	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,513	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 115,425	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,088)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 179,668	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ 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	39-3	hrs	\$	11,196	\$ 87,090	\$	11,196	\$ 87,090	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		1,244	9,677		1,244	9,677	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		12,440	96,767		12,440	96,767	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescripts				158,717		158,717	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Outservice Claims</u>	39-3					5,714		5,714	12
13	Other (specify): <u>Lab Therapy</u>	39-3					10,600		10,600	13
14	TOTAL			\$	24,880	\$ 193,534	\$ 175,031	24,880	\$ 368,565	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 Home Bridge Center# 0050153Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 15,295	\$ 15,295	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	510,620	510,620	3
4	Supply Inventory (priced at <u>cost</u>)	8,817	8,817	4
5	Short-Term Investments			5
6	Prepaid Insurance	41,880	41,880	6
7	Other Prepaid Expenses	1,778	1,778	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 578,390	\$ 578,390	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,435,303	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	106,759	250,759	16
17	Accumulated Depreciation (book methods)	(28,435)	(179,668)	17
18	Deferred Charges	7,500	27,900	18
19	Organization & Pre-Operating Costs	31,838	31,838	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,813)	(2,813)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Due from affiliate</u>	221,703		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 336,552	\$ 2,663,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 914,942	\$ 3,241,709	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 516,404	\$ 516,404	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	125,300	125,300	29
30	Accrued Salaries Payable	102,974	102,974	30
31	Accrued Taxes Payable (excluding real estate taxes)	161,434	161,434	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,795	23,795	32
33	Accrued Interest Payable	45,108	45,108	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Other accrued expenses</u>	12,575	12,575	36
37	<u>Line of credit</u>	373,990	373,990	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,361,580	\$ 1,361,580	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	308,000	308,000	39
40	Mortgage Payable		2,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Seller financing</u>		478,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 308,000	\$ 2,786,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,669,580	\$ 4,147,580	46
47	TOTAL EQUITY(page 18, line 24)	\$ (754,638)	\$ (905,871)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 914,942	\$ 3,241,709	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (281,068)	1
2	Restatements (describe):		2
3	Prior period adjustments	5,958	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (275,110)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(479,528)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (479,528)	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)	\$ (754,638)	24 *

* This must agree with page 17, line 47.

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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	\$ 2,907,510	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,907,510	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		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)	\$	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,907,510	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	587,170	31
32	Health Care	1,374,144	32
33	General Administration	678,002	33
B. Capital Expense			
34	Ownership	333,914	34
C. Ancillary Expense			
35	Special Cost Centers	368,565	35
36	Provider Participation Fee	45,243	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,387,038	40
41	Income before Income Taxes (line 30 minus line 40)**	(479,528)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (479,528)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 Home Bridge Center

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Report Period Beginning:

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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	1,760	1,760	\$ 112,789	\$ 64.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,406	15,406	492,459	31.97	3
4	Licensed Practical Nurses	5,537	5,537	130,764	23.62	4
5	CNAs & Orderlies	30,797	30,797	343,251	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,640	1,640	40,560	24.73	9
10	Activity Assistants					10
11	Social Service Workers	3,698	3,698	41,309	11.17	11
12	Dietician					12
13	Food Service Supervisor	961	961	9,875	10.28	13
14	Head Cook	2,212	2,212	34,619	15.65	14
15	Cook Helpers/Assistants	11,675	11,675	109,463	9.38	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	14,402	14,402	154,439	10.72	18
19	Laundry					19
20	Administrator	2,145	2,145	97,605	45.50	20
21	Assistant Administrator					21
22	Other Administrative	3,227	3,227	63,952	19.82	22
23	Office Manager					23
24	Clerical	3,329	3,329	104,692	31.45	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)	96,789	96,789	\$ 1,735,777 *	\$ 17.93	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	\$ 5,625	1-3	35
36	Medical Director	29,157	9-3	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)	\$ 34,782		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$ 961	45,625	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	961	\$ 45,625		53

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Ending: 12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc. - \$699
- (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. \$ 730 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? 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. \$ 45,243
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? 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? 0
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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.