

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0032946</u></p> <p>Facility Name: <u>LITCHFIELD TERRACE</u></p> <p>Address: <u>1024 EAST TYLER</u> <u>LITCHFIELD</u> <u>62056</u> Number City Zip Code</p> <p>County: <u>MONTGOMERY</u></p> <p>Telephone Number: <u>(217) 324-3842</u> Fax # <u>(217) 324-3942</u></p> <p>HFS ID Number: <u>36-1223347001</u></p> <p>Date of Initial License for Current Owners: <u>11/06/87</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MELVIN SIEGEL</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td></td> <td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MELVIN SIEGEL</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number LITCHFIELD TERRACE

0032946 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	65	Skilled (SNF)	65	23,725	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	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	20,822	66		20,888
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	20,822	66		20,888

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.04%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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 11/06/87

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/06/87 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 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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	112,782	3,535	5,020	121,337		121,337		121,337	1	
2	Food Purchase		113,586		113,586		113,586	(237)	113,349	2	
3	Housekeeping	57,774	10,889		68,663		68,663		68,663	3	
4	Laundry	27,319	3,054		30,373		30,373		30,373	4	
5	Heat and Other Utilities			43,211	43,211		43,211	150	43,361	5	
6	Maintenance	29,070		33,355	62,425		62,425	1,392	63,817	6	
7	Other (specify):*			4,129	4,129		4,129	1	4,130	7	
8	TOTAL General Services	226,945	131,064	85,715	443,724		443,724	1,306	445,030	8	
	B. Health Care and Programs										
9	Medical Director			12,182	12,182		12,182		12,182	9	
10	Nursing and Medical Records	588,058	26,676	4,391	619,125		619,125	(2,774)	616,351	10	
10a	Therapy									10a	
11	Activities	38,073	1,481	3,326	42,880		42,880	(3,000)	39,880	11	
12	Social Services	117,991	480		118,471		118,471		118,471	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	744,122	28,637	19,899	792,658		792,658	(5,774)	786,884	16	
	C. General Administration										
17	Administrative	98,525			98,525		98,525		98,525	17	
18	Directors Fees									18	
19	Professional Services			91,176	91,176		91,176	(61,547)	29,629	19	
20	Dues, Fees, Subscriptions & Promotions			7,143	7,143		7,143	(347)	6,796	20	
21	Clerical & General Office Expenses	26,184	3,828	18,360	48,372		48,372	34,947	83,319	21	
22	Employee Benefits & Payroll Taxes			152,172	152,172		152,172		152,172	22	
23	Inservice Training & Education							221	221	23	
24	Travel and Seminar			1,670	1,670		1,670	6,950	8,620	24	
25	Other Admin. Staff Transportation			9,312	9,312		9,312	3,083	12,395	25	
26	Insurance-Prop.Liab.Malpractice			54,792	54,792		54,792		54,792	26	
27	Other (specify):*							8,928	8,928	27	
28	TOTAL General Administration	124,709	3,828	334,625	463,162		463,162	(7,765)	455,397	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,095,776	163,529	440,239	1,699,544		1,699,544	(12,233)	1,687,311	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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,020
	REPAIRS & MAINTENANCE	0
		0
		5,020
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	8,931
	ELECTRICITY	18,074
	WATER	16,017
	CABLE TV - LOBBY	189
		0
		43,211
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE CONSULTANT	9,984
	EQUIPMENT MAINTENANCE & REPAIR	20,038
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,900
	FIRE SERVICE	1,433
		0
		0
		0
		0
		33,355
7	OTHER	
	SCAVENGER	4,129
	SECURITY SERVICE	0
		0
		0
		4,129
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,182
		12,182

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	3,791
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		4,391
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,326
		0
		3,326
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		0
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	0
18	DIRECTORS FEES		
	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	8,732
	ADMINISTRATIVE CONSULTANTS	XIX C	6,060
	PROFESSIONAL FEES	XIX C	19,575
	BOOKKEEPING/ADMINISTRATIVE SERVICE		56,809
			91,176
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	24
	EMPLOYEE WANT ADS	XIX F	49
	CONTRIBUTIONS	VI 20 XIX F	430
	DUES & SUBSCRIPTIONS	XIX F	5,593
	LICENSES & PERMITS	XIX F	747
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	110
	PATIENT BACKGROUND CHECKS	XIX F	190
			7,143
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		60
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,630
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		14,670
	MESSENGER SERVICE		0
			0
			18,360

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	82,977
	UNEMPLOYMENT COMPENSATION	XIX D	18,444
	WORKERS COMPENSATION INSURANC	XIX D	31,546
	HOSPITALIZATION INSURANCE	XIX D	15,036
	EMPLOYEE BENEFITS - OTHER	XIX D	4,169
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
	CHICAGO HEAD TAX	XIX D	0
			0
			152,172
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		0
			0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	1,670
	TRAVEL	XIX G	0
			1,670
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		9,312
			9,312
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		54,792
			54,792
27	OTHER		
	BAD DEBTS	VI 24	0
			0

GRAND TOTAL COLUMN 3 OTHER

440,239

LITCHFIELD TERRACE
SCHEDULES
12/31/2009

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	113,586
LESS SALES TAX	<u>(237)</u>
NET FOOD	113,349

TOTAL PATIENT CENSUS	20,888
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	62,664

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	62,664
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	62,664

NET FOOD	113,349
DIVIDE TOTAL MEALS/YEAR	<u>62,664</u>

COST PER MEAL	1.81
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number LITCHFIELD TERRACE

#0032946

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

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			2,869	2,869		2,869	21,178	24,047			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			956	956		956	42,322	43,278			32
33	Real Estate Taxes			20,797	20,797		20,797		20,797			33
34	Rent-Facility & Grounds			65,237	65,237		65,237	(60,165)	5,072			34
35	Rent-Equipment & Vehicles			16,535	16,535		16,535	5,682	22,217			35
36	Other (specify):*											36
37	TOTAL Ownership			106,394	106,394		106,394	9,017	115,411			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,587	35,587		35,587		35,587			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,587	35,587		35,587		35,587			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,095,776	163,529	582,220	1,841,525		1,841,525	(3,216)	1,838,309			45

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

Facility Name & ID Number LITCHFIELD TERRACE

0032946

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,430	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(237)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,630)	21		18
19	Entertainment		20		19
20	Contributions	(430)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(24)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,891)		\$	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)	(1,325)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,325)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (3,216)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

LITCHFIELD TERRACE

ID# 0032946

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	DEFERRED MAINTENANCE	\$	6	1
2				2
3				3
4				4
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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 LITCHFIELD TERRACE# 0032946

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 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	(237)	0	0	0	0	0	0	0	0	0	0	(237)	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	150	0	0	0	0	0	0	0	0	150	5
6	Maintenance	0	(9,984)	11,376	0	0	0	0	0	0	0	0	1,392	6
7	Other (specify):*	0	0	1	0	0	0	0	0	0	0	0	1	7
8	TOTAL General Services	(237)	(9,984)	11,527	0	1,306	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	(3,000)	226	0	0	0	0	0	0	0	0	(2,774)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,000)	0	0	0	0	0	0	0	0	0	(3,000)	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	(6,000)	226	0	(5,774)	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	(62,869)	1,322	0	0	0	0	0	0	0	0	(61,547)	19
20	Fees, Subscriptions & Promotions	(454)	0	107	0	0	0	0	0	0	0	0	(347)	20
21	Clerical & General Office Expenses	(3,630)	0	38,577	0	0	0	0	0	0	0	0	34,947	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	221	0	0	0	0	0	0	0	0	221	23
24	Travel and Seminar	0	0	6,950	0	0	0	0	0	0	0	0	6,950	24
25	Other Admin. Staff Transportation	0	0	3,083	0	0	0	0	0	0	0	0	3,083	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	8,928	0	0	0	0	0	0	0	0	8,928	27
28	TOTAL General Administration	(4,084)	(62,869)	59,188	0	(7,765)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,321)	(78,853)	70,941	0	(12,233)	29							

STATE OF ILLINOIS

Facility Name & ID Number LITCHFIELD TERRACE

0032946

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	2,430	0	39	18,709	0	0	0	0	0	0	0	21,178	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	85	42,237	0	0	0	0	0	0	0	42,322	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,072	(65,237)	0	0	0	0	0	0	0	(60,165)	34
35	Rent-Equipment & Vehicles	0	0	5,682	0	0	0	0	0	0	0	0	5,682	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,430	0	10,878	(4,291)	0	9,017	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,891)	(78,853)	81,819	(4,291)	0	(3,216)	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
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING
		VANDALIA TERRACE	VANDALIA	ENTERPRISES		
SEE ATTACHED LIST		GOLDEN MOMENTS	JACKSONVILLE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 MAINTENANCE CONSULTAN	\$ 9,984	MAVIN ENTERPRISES, LTD		\$	\$ (9,984)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	3,000				(3,000)	2
3	V	11 ACTIVITIES CONSULTANT	3,000				(3,000)	3
4	V	19 ADMIN. /BKKP. FEES	56,809				(56,809)	4
5	V	19 ADMIN. /CONSULT. FEES	6,060				(6,060)	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		\$ 78,853			\$	\$ * (78,853)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 ELECTRICITY/GAS	\$	MAVIN ENTERPRISES, LTD		\$ 150	\$	150	15
16	V	6 MAINTENANCE SALARIES				11,322		11,322	16
17	V	6 MAINTENANCE & REPAIR				54		54	17
18	V	7 SCAVENGER				1		1	18
19	V	10 PSYCHO-SOCIAL & NURSING CONSULT				226		226	19
20	V	19 PROFESSIONAL FEES				1,322		1,322	20
21	V	20 ADVERTISING				107		107	21
22	V	21 TOTAL OFFICE				38,577		38,577	22
23	V	23 SEMINARS				221		221	23
24	V	24 TRAVEL				6,950		6,950	24
25	V	25 TRANSPORTATION				3,083		3,083	25
26	V	27 EMPLOYEE BENEFITS				8,928		8,928	26
27	V	30 DEPRECIATION (SL)				39		39	27
28	V	32 INTEREST				85		85	28
29	V	34 OFFICE RENT				5,072		5,072	29
30	V	35 EQUIPMENT RENT				5,682		5,682	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 81,819	\$ *	81,819	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 65,237	IDEA ASSOCIATES		\$	(65,237) 15
16	V	30 DEPRECIATION				18,709	18,709 16
17	V	32 INTEREST				42,237	42,237 17
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 65,237			\$ 60,946	\$ * (4,291) 39

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

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	MELVIN SIEGEL	PRESIDENT	ADMINISTR.	19.97				SALARY	\$ 17,250	17-1	1
2					SEE						2
3					ATTACHED						3
4					SCHEDULE						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,250		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 LITCHFIELD TERRACE

0032946 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization MAVIN ENTERPRISES, LTD.
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-0100
 Fax Number (847) 679-0647

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	5	ELECTRICITY/GAS	PATIENT DAYS	92,428	5	\$ 662	\$ 20,888	\$ 150	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	92,428	5	50,100	20,888	11,322	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	92,428	5	241	20,888	54	3
4	7	SCAVENGER	PATIENT DAYS	92,428	5	6	20,888	1	4
5	10	PSYCHO-SOCIAL & NURSING	PATIENT DAYS	92,428	5	1,000	20,888	226	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	92,428	5	5,848	20,888	1,322	6
7	20	ADVERTISING	PATIENT DAYS	92,428	5	472	20,888	107	7
8	21	TOTAL OFFICE	PATIENT DAYS	92,428	5	170,703	20,888	38,577	8
9	23	SEMINARS	PATIENT DAYS	92,428	5	980	20,888	221	9
10	24	TRAVEL	PATIENT DAYS	92,428	5	30,753	20,888	6,950	10
11	25	TRANSPORTATION	PATIENT DAYS	92,428	5	13,644	20,888	3,083	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	92,428	5	39,504	20,888	8,928	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	92,428	5	173	20,888	39	13
14	32	INTEREST	PATIENT DAYS	92,428	5	375	20,888	85	14
15	34	OFFICE RENT	PATIENT DAYS	92,428	5	22,445	20,888	5,072	15
16	35	EQUIPMENT RENT	PATIENT DAYS	92,428	5	25,141	20,888	5,682	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 362,047	\$ 182,725	\$ 81,819	25

Facility Name & ID Number

LITCHFIELD TERRACE

0032946

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	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		RELATED PARTY						\$	\$			\$	1						
2		IDEA ASSOCIATES											2						
3		BANK FINANCIAL		X	MORTGAGE	\$6,755.00	01/04	874,500	804,084			42,237	3						
4													4						
5		MGMT ALLOCATIONS										85	5						
		Working Capital																	
6		BANK FINANCIAL			LINE OF CREDIT	DEMAND	11/01/97	150,000	7,019		PRIME+	956	6						
7													7						
8													8						
9		TOTAL Facility Related				\$6,755.00		\$ 1,024,500	\$ 811,103			\$ 43,278	9						
		B. Non-Facility Related*																	
10		IRS, IDR, ETC		X	LATE FEES								10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$ 1,024,500	\$ 811,103			\$ 43,278	15						

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.	\$	18,716	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.)	\$	19,658	2
3. Under or (over) accrual (line 2 minus line 1).	\$	942	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	19,855	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.	\$	20,797	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	16,804	8
	2005	17,217	9
	2006	17,600	10
	2007	18,531	11
	2008	19,658	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

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL

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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>19,657.94</u>	\$ <u>19,657.94</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	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	65		1987	\$ 589,342	\$ 18,709	31.5	\$ 18,709	\$	\$ 355,416	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		1989	12,200	127	20	610	483	7,673	9
10	VARIOUS		1990	11,968	349	20	598	249	8,479	10
11	VARIOUS		1991	4,250	135	20		(135)	4,250	11
12	VARIOUS		1992	14,226	197	20	711	514	9,830	12
13	VARIOUS		1993	5,350	170	20		(170)	5,350	13
14	VARIOUS		1994	2,312	25	20		(25)	2,312	14
15	GARBAGE DISPOSAL		1996	695		20	35	35	467	15
16	TILE		1997	2,778	71	20	139	68	1,683	16
17	WATER HEATER		1998	2,107	54	20	105	51	1,207	17
18	AIR CONDITIONERS		2000	1,477	56	27.5	54	(2)	514	18
19	REPAIR ROOF		2000	1,700	64	27.5	62	(2)	590	19
20	SPRINKLERS		2000	2,961	112	27.5	108	(4)	1,028	20
21	ROOF REPAIR		2002	6,450	235	27.5	235		1,704	21
22	ROOF REPAIR		2006	3,800	138	27.5	138		553	22
23	INSTALLATION OF CLOSET SPRINKLER PROTECTION		2009	8,225	62	27.5	62		62	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

*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 LITCHFIELD TERRACE

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)	\$ 669,841	\$ 20,504		\$ 21,566	\$ 1,062	\$ 401,118	70

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

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	\$ 27,768	\$ 1,074	\$ 2,442	\$ 1,368	8-10	\$ 22,325	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	29,151					29,151	73
74	MGMT ALLOCATIONS		39	39				74
75	TOTALS	\$ 56,919	\$ 1,113	\$ 2,481	\$ 1,368		\$ 51,476	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)	\$ 726,760	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,617	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,047	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,430	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 452,594	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 - RELATED PARTY

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

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. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

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: \$ 6,589 Description: COPIER-\$3,686; DISHWASHER-\$935; ICE MACHINE \$1,968

(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	<u>MAINT, ACTIVITY</u>	<u>2007 FORD VAN</u>	\$ <u>797.54</u>	\$ <u>9,946</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>797.54</u>	\$ <u>9,946</u>	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs								4
5	Physician Care		visits								5
6	Dental Care		visits			N/A					6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LITCHFIELD TERRACE# 0032946Report Period Beginning: 01/01/2009Ending: 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	\$ (75,356)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	257,724		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,468		6
7	Other Prepaid Expenses	3,608		7
8	Accounts Receivable (owners or related parties)	1,907,916		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,105,360	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	61,477		15
16	Equipment, at Historical Cost	75,641		16
17	Accumulated Depreciation (book methods)	(100,770)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 36,348	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,141,708	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 626,900	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	237,607		29
30	Accrued Salaries Payable	44,880		30
31	Accrued Taxes Payable (excluding real estate taxes)	202,998		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,855		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,132,240	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,132,240	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,009,468	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,141,708	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 918,256	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	17,958	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 936,214	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	73,254	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)	\$ 73,254	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)	\$ 1,009,468	24 *

* This must agree with page 17, line 47.

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	\$ 1,914,779	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,914,779	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)	\$ 1,914,779	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	443,724	31
32	Health Care	792,658	32
33	General Administration	463,162	33
B. Capital Expense			
34	Ownership	106,394	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	35,587	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,841,525	40
41	Income before Income Taxes (line 30 minus line 40)**	73,254	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 73,254	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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 LITCHFIELD TERRACE

0032946

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	2,104	2,622	\$ 72,875	\$ 27.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,282	3,850	88,763	23.06	3
4	Licensed Practical Nurses	6,993	7,518	129,011	17.16	4
5	CNAs & Orderlies	22,789	24,565	254,765	10.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,717	2,895	38,073	13.15	10
11	Social Service Workers	6,679	7,580	117,991	15.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,338	10,106	112,782	11.16	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,068	29,070	14.06	17
18	Housekeepers	5,373	5,789	57,774	9.98	18
19	Laundry	2,702	2,761	27,319	9.89	19
20	Administrator	1,952	2,120	81,275	38.34	20
21	Assistant Administrator					21
22	Other Administrative	550	550	17,250	31.36	22
23	Office Manager					23
24	Clerical	1,850	2,134	26,184	12.27	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 C: <u>Care Plan Coord</u>	1,886	1,962	42,644	21.73	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	70,175	76,520	\$ 1,095,776 *	\$ 14.32	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	M	\$ 5,020	1-3	35
36	Medical Director	O	12,182	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,326	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,128		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8						N/A						
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number LITCHFIELD TERRACE# 0032946Report Period Beginning: 01/01/2009 Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$5,343
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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. \$ 35,587
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? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
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. \$ 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.