



Facility Name & ID Number Care Center of Abingdon

# 0047951 Report Period Beginning: 10/1/09 Ending: 9/30/10

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 N/A

	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	82	Skilled (SNF)	82	29,930	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	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	10,448	5,748	5,385	21,581	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	10,448	5,748	5,385	21,581	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.10%

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 04/01/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/06 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 82 and days of care provided 2,183

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/10 Fiscal Year: 09/30/10

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

Facility Name & ID Number Care Center of Abingdon # 0047951 Report Period Beginning: 10/1/09 Ending: 9/30/10

**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
	<b>A. General Services</b>										
1	Dietary	172,900	12,713	5,161	190,774		190,774		190,774		1
2	Food Purchase		167,423		167,423		167,423		167,423		2
3	Housekeeping	103,763	24,040		127,803		127,803		127,803		3
4	Laundry	37,573	11,788		49,361		49,361		49,361		4
5	Heat and Other Utilities			92,773	92,773		92,773		92,773		5
6	Maintenance	28,758	20,315	33,393	82,466		82,466		82,466		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	342,994	236,279	131,327	710,600		710,600		710,600		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,500	11,500		11,500		11,500		9
10	Nursing and Medical Records	1,077,063	225,754	5,489	1,308,306		1,308,306		1,308,306		10
10a	Therapy			153,946	153,946		153,946		153,946		10a
11	Activities	73,195	949	138	74,282		74,282		74,282		11
12	Social Services	18,329			18,329		18,329		18,329		12
13	CNA Training										13
14	Program Transportation			625	625	2,083	2,708		2,708		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,168,587	226,703	171,698	1,566,988	2,083	1,569,071		1,569,071		16
	<b>C. General Administration</b>										
17	Administrative	91,980			91,980		91,980		91,980		17
18	Directors Fees							2,271	2,271		18
19	Professional Services			183,929	183,929		183,929	1,095	185,024		19
20	Dues, Fees, Subscriptions & Promotions			44,941	44,941		44,941	(34,935)	10,006		20
21	Clerical & General Office Expenses	44,026	24,888	24,134	93,048		93,048	110	93,158		21
22	Employee Benefits & Payroll Taxes			347,870	347,870		347,870		347,870		22
23	Inservice Training & Education			517	517		517		517		23
24	Travel and Seminar			343	343		343		343		24
25	Other Admin. Staff Transportation			4,165	4,165	(2,083)	2,082		2,082		25
26	Insurance-Prop.Liab.Malpractice			32,929	32,929		32,929		32,929		26
27	Other (specify):* <b>See Att Sch V</b>	29,748		108,508	138,256		138,256	(138,256)			27
28	<b>TOTAL General Administration</b>	165,754	24,888	747,336	937,978	(2,083)	935,895	(169,715)	766,180		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,677,335	487,870	1,050,361	3,215,566		3,215,566	(169,715)	3,045,851		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Care Center of Abingdon

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			20,693	20,693		20,693	53,082	73,775			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			66,000	66,000		66,000		66,000			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			2,233	2,233		2,233		2,233			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			268,926	268,926		268,926	(126,918)	142,008			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			14,902	14,902		14,902		14,902			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,690	5,690		5,690		5,690			41
42	Provider Participation Fee			44,895	44,895		44,895		44,895			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			65,487	65,487		65,487		65,487			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,677,335	487,870	1,384,774	3,549,979		3,549,979	(296,633)	3,253,346			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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		V-30		9
10	Interest and Other Investment Income		V-32		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	(107,079)	V-27		24
25	Fund Raising, Advertising and Promotional	(34,937)	V-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 See Att Sch VI	(31,177)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (173,193)		\$	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)	(126,918)		34
35	Other- Attach Schedule See Att Sch III	3,478		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (123,440)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (296,633)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

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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	<b>Total</b>	0	49



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Care Center of Abingdon# 0047951

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## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(126,918)	0	0	0	0	0	0	0	0	0	(126,918)	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>(126,918)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(126,918)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	0	(126,918)	0	0	0	0	0	0	0	0	0	(126,918)	45



Facility Name & ID Number

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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
None	N/A	See Attached Schedule I		See Attached Schedule I		

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 Facility Rent	\$ 180,000	Abingdon West Martin, LLC	N/A	\$ 53,082	\$ (126,918)	1
2	V							2
3	V			See Att Schedule IV and Independent Accountant's Report				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 180,000			\$ 53,082	\$ * (126,918)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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	See Attached Schedule II & III								\$ 2,271	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,271		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

SEE ACCOUNTANTS' COMPILATION REPORT

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Unlimited Development, Inc.

Street Address

285 S Farnham

City / State / Zip Code

Galesburg, IL 61401

Phone Number

(309) 343-1550

Fax Number

(309) 343-2857

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Sch II & III							3,478	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				\$	\$		\$	3,478

SEE ACCOUNTANTS' COMPILATION REPORT

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**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6	Miscellaneous										6							
7	Less Interest Income										7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$			\$	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # 26

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2009 report.		\$	<b>48,267</b>		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.)		\$	<b>65,196</b>		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>16,929</b>		3	
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>49,071</b>		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>66,000</b>		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2005	N/A	8	<b>FOR BHF USE ONLY</b>		
	2006	<b>55,131</b>	9			
	2007	<b>61,472</b>	10			
	2008	<b>63,857</b>	11			
	2009	<b>65,196</b>	12			
<b>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained. Amount accrued includes estimated taxes for 9 months based on fiscal year end. Estimate is based on 2009 bill. Taxes paid are for the entire 2009 tax bill.</b>				13	FROM R. E. TAX STATEMENT FOR 2009 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,366 B. General Construction Type: Exterior Brick Frame Wood 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.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an unlabeled column. Row 1: Facility, 5.85 Acres, 2006, \$60,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, #VALUE!, (blank), \$60,000, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon

# 0047951

Report Period Beginning:

10/1/09

Ending:

9/30/10

**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	82	2006		\$ 1,478,900	\$ 36,979	40	\$ 36,979	\$	\$ 169,457
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Sidewalk		2007	5,571	372	15	372		1,238
10	Handrails		2008	2,981	199	15	199		464
11	Rewire House		2008	12,000	600	20	600		1,250
12	Concrete Ramp		2008	5,640	376	15	376		721
13	Furnace and A/C Unit		2009	6,145	512	12	512		811
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
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

SEE ACCOUNTANTS' COMPILATION REPORT



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)	\$ 1,511,237	\$ 39,038		\$ 39,038	\$	\$ 173,941	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Care Center of Abingdon

# 0047951

Report Period Beginning:

10/1/09

Ending:

9/30/10

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	\$ 243,717	\$ 25,282	\$ 25,282	\$	5-15 yrs	\$ 101,643	71
72	Current Year Purchases	31,282	2,615	2,615		5-12 yrs	2,615	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 274,999	\$ 27,897	\$ 27,897	\$		\$ 104,258	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	Patient Care	2003 GMC G3500 Van	2006	\$ 29,848	\$ 6,840	\$ 6,840	\$	4 yrs	\$ 29,848	76
77										77
78										78
79										79
80	TOTALS			\$ 29,848	\$ 6,840	\$ 6,840	\$		\$ 29,848	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)	\$ 1,876,084	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,775	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,775	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 308,047	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: Abingdon West Martin, LLC

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			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 N/A N/A

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 2,233 Description: See Attached Schedule XII

(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.	<u>/2011</u>	\$ <u>N/A</u>
13.	<u>/2012</u>	\$ <u>N/A</u>
14.	<u>/2013</u>	\$ <u>N/A</u>

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): _____									12	
13	Other (specify): _____									13	
14	TOTAL			\$		\$	\$		\$	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon# 0047951Report Period Beginning: 10/1/09Ending: 9/30/10

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 16,555	\$ 142,272	1
2	Cash-Patient Deposits	11,253	11,253	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	488,879	488,879	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,905	58,905	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	74,933		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 650,525	\$ 701,309	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost		1,478,900	14
15	Leasehold Improvements, at Historical Cost	32,337	32,337	15
16	Equipment, at Historical Cost	143,747	304,847	16
17	Accumulated Depreciation (book methods)	(64,752)	(308,047)	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): <u>See Att Sch VII</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 111,332	\$ 1,568,037	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 761,857	\$ 2,269,346	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 39,865	\$ 39,865	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,692	10,692	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,504	44,504	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,457	6,457	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,071	49,071	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivision Payable</u>	1,002,331	1,945,914	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,152,920	\$ 2,096,503	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>Security Deposits</u>	10,500	10,500	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 10,500	\$ 10,500	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,163,420	\$ 2,107,003	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (401,563)	\$ 162,343	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 761,857	\$ 2,269,346	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(187,757)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">See Attached Sch X</a>	<b>(9,639)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(197,396)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(204,167)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(204,167)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(401,563)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon# 0047951Report Period Beginning: 10/1/09Ending: 9/30/10

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,275,880	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,275,880	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	25,142	6
7	Oxygen	1,710	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 26,852	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	7,542	12
13	Barber and Beauty Care	3,873	13
14	Non-Patient Meals	10,796	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,310	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	416	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 31,937	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	5,416	24
25	Interest and Other Investment Income***	3,187	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,603	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>		28
28a	<b>See Att Schedule XI</b>	2,540	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,540	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,345,812	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	710,600	31
32	Health Care	1,566,988	32
33	General Administration	937,978	33
<b>B. Capital Expense</b>			
34	Ownership	268,926	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	20,592	35
36	Provider Participation Fee	44,895	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,549,979	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(204,167)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (204,167)	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. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number Care Center of Abingdon

# 0047951

Report Period Beginning:

10/1/09

Ending:

9/30/10

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	1,831	1,948	\$ 48,708	\$ 25.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,904	5,217	104,347	20.00	3
4	Licensed Practical Nurses	14,812	15,842	242,860	15.33	4
5	CNAs & Orderlies	59,286	63,748	612,622	9.61	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	244	244	3,236	13.26	9
10	Activity Assistants	6,320	6,724	69,959	10.40	10
11	Social Service Workers	1,276	1,358	18,329	13.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,914	19,058	172,900	9.07	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,130	28,758	13.50	17
18	Housekeepers	11,570	12,309	103,763	8.43	18
19	Laundry	4,266	4,538	37,573	8.28	19
20	Administrator	1,713	1,823	65,722	36.05	20
21	Assistant Administrator	2,056	2,188	26,258	12.00	21
22	Other Administrative	2,072	2,204	29,748	13.50	22
23	Office Manager					23
24	Clerical	4,034	4,391	44,026	10.03	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	626	666	6,157	9.24	31
32	Other Health Care(specify)	4,188	4,455	62,369	14.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,114	148,843	\$ 1,677,335 *	\$ 11.27	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	\$ 5,161	1-3	35
36	Medical Director	11,500	9-3	36
37	Medical Records Consultant	1,320	10-3	37
38	Nurse Consultant	1,245	10-3	38
39	Pharmacist Consultant	2,924	10-3	39
40	Physical Therapy Consultant	80,515	10a-3	40
41	Occupational Therapy Consultant	55,565	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	17,866	10a-3	43
44	Activity Consultant	0	11-3	44
45	Social Service Consultant	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	0	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 176,096		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT



**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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Care Center of Abingdon

# 0047951

Report Period Beginning: 10/1/09

Ending: 9/30/10

**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. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (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? 9 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,383 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 44,895  
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- 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? Yes  
Firm Name: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**