

Facility Name & ID Number The Clayberg Fulton County Nursing Center

0014290 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	49	Skilled (SNF)	49	17,885	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	49	TOTALS	49	17,885	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		Total
8	SNF	0	350	1,417	1,767	8
9	SNF/PED					9
10	ICF	10,166	3,150	10	13,326	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,166	3,500	1,427	15,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.39%

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

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meal Delivery

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 7/6/1969

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

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 49 and days of care provided 1,417

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2018 Fiscal Year: 11/30/2018

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

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification	Reclassified Total	Adjustments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	262,171	13,152	4,167	279,490		279,490		279,490		1
2	Food Purchase		103,884		103,884		103,884	(4,304)	99,580		2
3	Housekeeping	157,609	15,889		173,498		173,498		173,498		3
4	Laundry		23,888		23,888		23,888		23,888		4
5	Heat and Other Utilities			71,030	71,030		71,030	(3,946)	67,084		5
6	Maintenance	67,346	7,135	104,313	178,794		178,794		178,794		6
7	Other (specify):*										7
8	TOTAL General Services	487,126	163,948	179,510	830,584		830,584	(8,250)	822,334		8
	B. Health Care and Programs										
9	Medical Director			250	250		250		250		9
10	Nursing and Medical Records	1,099,764	91,101	29,414	1,220,279		1,220,279		1,220,279		10
10a	Therapy										10a
11	Activities	99,296	4,513	3,567	107,376		107,376		107,376		11
12	Social Services	42,832			42,832		42,832		42,832		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,241,892	95,614	33,231	1,370,737		1,370,737		1,370,737		16
	C. General Administration										
17	Administrative	81,079		1,975	83,054		83,054		83,054		17
18	Directors Fees										18
19	Professional Services			20,768	20,768		20,768		20,768		19
20	Dues, Fees, Subscriptions & Promotions			41,378	41,378		41,378	(31,675)	9,703		20
21	Clerical & General Office Expenses	58,913	9,756	8,964	77,633		77,633		77,633		21
22	Employee Benefits & Payroll Taxes			610,156	610,156		610,156		610,156		22
23	Inservice Training & Education			2,126	2,126		2,126		2,126		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			5,892	5,892		5,892		5,892		25
26	Insurance-Prop.Liab.Malpractice			42,943	42,943		42,943		42,943		26
27	Other (specify):* Marketing Director	27,847			27,847		27,847		27,847		27
28	TOTAL General Administration	167,839	9,756	734,202	911,797		911,797	(31,675)	880,122		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,896,857	269,318	946,943	3,113,118		3,113,118	(39,925)	3,073,193		29

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

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

Facility Name & ID Number

The Clayberg Fulton County Nursing Center

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12/1/2017

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			66,667	66,667		66,667		66,667		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			19,990	19,990		19,990		19,990		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			5,126	5,126		5,126		5,126		35
36	Other (specify):*										36
37	TOTAL Ownership			91,783	91,783		91,783		91,783		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			5,803	5,803		5,803		5,803		38
39	Ancillary Service Centers	113,403	11,191	169,728	294,322		294,322		294,322		39
40	Barber and Beauty Shops		16		16		16		16		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			123,482	123,482		123,482		123,482		42
43	Other (specify):* lab and radiology			3,927	3,927		3,927		3,927		43
44	TOTAL Special Cost Centers	113,403	11,207	302,940	427,550		427,550		427,550		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,010,260	280,525	1,341,666	3,632,451		3,632,451	(39,925)	3,592,526		45

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

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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	(4,304)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,946)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(31,675)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (39,925)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (39,925)		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

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Fulton County	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	22 IMRF	\$ 205,742	Fulton County	100.00%	\$ 205,742	\$
2	V	22 FICA	156,980	Fulton County	100.00%	156,980	
3	V	22 Workers' Comp Insurance	55,323	Fulton County	100.00%	55,323	
4	V	26 Property & Liability Insurance	42,943	Fulton County	100.00%	42,943	
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 460,988			\$ 460,988	\$ *

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

Facility Name & ID Number The Clayberg Fulton County Nursing Center # 0014290 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	None								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number The Clayberg Fulton County Nursing Center

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12/1/2017

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number The Clayberg Fulton County Nursing Center

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Report Period Beginning:

12/1/2017

Ending:

11/30/2018

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	First Midstate Inc.		X	Capital Improvements	\$6,601.03	11/30/16	\$ 1,000,000	\$ 950,000	12/1/2036	4.5000	\$ 19,990	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$6,601.03		\$ 1,000,000	\$ 950,000			\$ 19,990	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,000,000	\$ 950,000			\$ 19,990	15						

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

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

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

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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 must accompany the cost report.			
1.	Real Estate Tax accrual used on 2017 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2013	_____	8	
		2014	_____	9	
		2015	_____	10	
		2016	_____	11	
		2017	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2017 \$		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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Clayberg Fulton County Nursing Center COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0014290

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A)	(B)	(C)	(D) <u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

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12/1/2017

Ending:

11/30/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Building Site</u>	<u>217,800</u>	<u>1969</u>	<u>\$ 5,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	217,800		\$ 5,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	49		1969		\$ 271,336	\$	40	\$	\$	\$ 271,336	4
5			1978		8,009		20			8,009	5
6			1979		52,096		30			52,096	6
7											7
8											8
	Improvement Type**										
9		OFFICE REMODEL		1983	2,546		10			2,546	9
10		SHED, ROOF AND FLOOR TILE		1987	5,429		20 TO 25			5,429	10
11		IDPA ADJUSTMENT		1989	1,806		20			1,806	11
12		ROAD REPAIR		1994	13,496		5			13,496	12
13		STORAGE BUILDING ADDITION		1995	4,265		20			4,265	13
14		STORAGE BUILDING ADDITION		1996	12,141		20			12,141	14
15		LAUNDRY FACILITY		1997	15,274		20			15,242	15
16		H/C SYSTEM		2000	4,564	228	20	228		4,146	16
17		WALK, PATH		2001	4,177		15			4,177	17
18		WALK, PATH		2002	1,357		15			1,357	18
19		AVIARY		2002	4,740		15			4,740	19
20		TWO A/C UNITS		2004	4,583		10			4,583	20
21		TWO METAL DOORS		2005	1,166	39	30	39		534	21
22		WALL COVERINGS		2005	697		5			697	22
23		SMOKE DETECTORS		2005	2,915		10			2,915	23
24		KITCHEN FIRE SYSTEM		2005	2,877	82	35	82		1,116	24
25		SIDEWALK		2005	802	54	15	54		722	25
26		WALL H/C UNITS		2005	2,729		10			2,729	26
27		HARBOR IN GARDEN		2005	868	35	25	35		457	27
28		WATER MAIN		2006	9,291	232	40	232		2,865	28
29		SPRINKLER SYSTEM/CEILING UPGRADE		2007	138,564	9,238	15	9,238		104,693	29
30		PACKAGED UNIT AND DUCT WORK		2008	6,105	407	15	407		4,103	30
31		FIRE PROTECTION - SPRINKLER SYSTEM		2009	14,700	980	15	980		8,820	31
32		WALL PAPER		2010	6,294	419	15	419		3,671	32
33		DINING DOOR		2012	3,092	104	30	104		696	33
34		HEAT/COOL WALL AIR CONDITIONER		2012	1,912	191	10	191		1,290	34
35		3 HEAT/COOL WALL AIR CONDITIONERS		2012	2,166	217	10	217		1,390	35
36		4 THROUGH WALL H/C UNITS		2013	4,607	461	10	461		2,479	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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 DOOR ALARM AND OPENERS	2013	\$ 31,838	\$ 1,591	20	\$ 1,591	\$	\$ 8,357	37
38 ENTRANCE REPLACEMENT	2013	122,450	4,082	30	4,082		21,089	38
39 FLOOR - DINING ROOM	2015	11,222	748	15	748		2,244	39
40 AMANA AIR CONDITIONER	2015	2,709	180	15	180		542	40
41 FIRE WALL PROTECTION BARRIERS	2016	10,000	400	15	400		1,100	41
42 UNIVERSAL GAS WATER HEATER	2016	6,228	415	15	415		1,142	42
43 SILENT KNIGHT 10 ZONE ALARM	2016	2,560	171	15	171		413	43
44 PARKING LOT EXTENSION	2017	54,387	3,625	15	3,625		4,834	44
45 ROOF REPLACEMENT	2017	257,439	17,163	15	17,163		20,023	45
46 WINDOW REPLACEMENT	2018	144,487	3,612	20	3,612		3,612	46
47 HVAC MODIFICATION	2018	43,947	1,465	15	1,465		1,465	47
48 NEW CIRCUITS INSTALLED FOR GENERATOR	2018	2,525	95	20	95		95	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)		\$ 1,294,396	\$ 46,234		\$ 46,234	\$	\$ 609,462	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 174,891	\$ 16,763	\$ 16,763	\$	3 to 20	\$ 111,191	71
72	Current Year Purchases	30,255	3,670	3,670		5 to 10	3,670	72
73	Fully Depreciated Assets	189,755				3 to 20	189,755	73
74								74
75	TOTALS	\$ 394,901	\$ 20,433	\$ 20,433	\$		\$ 304,616	75

D. Vehicle Costs. (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 Transportation	2000 Chevrolet Bus	2000	\$ 42,641	\$	\$	\$	5	\$ 42,641	76
77	Pickup, delivery, & plowing	2001 Ford Truck w/plow	2001	23,817				5	23,817	77
78										78
79										79
80	TOTALS			\$ 66,458	\$	\$	\$		\$ 66,458	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 1,760,755	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,667	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)	\$ 980,536	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	Remodel/Addition	\$ 569,050	92
93			93
94			94
95		\$ 569,050	95

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

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

Facility Name & ID Number The Clayberg Fulton County Nursing Center

0014290

Report Period Beginning: 12/1/2017

Ending: 11/30/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

**

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 5,126

Description: See attachment, page 23

(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. /2019 \$ _____

13. /2020 \$ _____

14. /2021 \$ _____

* 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 2 3 4			
		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		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39-3	hrs	\$	1,266	\$ 69,094	\$	1,266	\$ 69,094	1		
2	Licensed Speech and Language Development Therapist	39-3	hrs		864	23,025		864	23,025	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	39-3	hrs		921	72,373		921	72,373	4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy	39-3	# of prescripts		5,655	5,236		5,655	5,236	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Other (specify): <u>Stock Drugs</u>	39-2					11,191		11,191	12		
13	Other (specify): <u>Radiology</u>	39-3				1,444			1,444	13		
14	TOTAL			\$	8,706	\$ 171,172	\$ 11,191	8,706	\$ 182,363	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 The Clayberg Fulton County Nursing Center

0014290

Report Period Beginning: 12/1/2017

Ending: 11/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2018

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,201,704	\$	1
2	Cash-Patient Deposits	3,721		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>115,818</u>)	475,244		3
4	Supply Inventory (priced at <u>Cost</u>)	7,943		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	517,104		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,205,716	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	1,294,395		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	461,360		16
17	Accumulated Depreciation (book methods)	(980,536)		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 (spe CIP)	569,050		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,349,269	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,554,985	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 43,192	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,721		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,253		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	143,046		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred Property Taxes</u>	517,104		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 738,316	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	950,000		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)	\$ 950,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,688,316	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,866,669	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,554,985	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,943,604	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,943,604	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(537,923)	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)	\$ (537,923)	17
	B. Transfers (Itemize):		
18	Transfer in from County IMRF Fund	205,742	18
19	Transfer in from County FICA Fund	156,980	19
20	Transfer in from County Insurance Fund	98,266	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 460,988	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,866,669	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Clayberg Fulton County Nursing Center# 0014290Report Period Beginning: 12/1/2017Ending: 11/30/2018**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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,595,615	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,595,615	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	10,395	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)	\$ 10,395	23
D. Non-Operating Revenue			
24	Contributions	6,034	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,034	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Property Taxes</u>	477,703	28
28a	<u>Miscellaneous Income</u>	4,781	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 482,484	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,094,528	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	830,584	31
32	Health Care	1,370,737	32
33	General Administration	911,797	33
B. Capital Expense			
34	Ownership	91,783	34
C. Ancillary Expense			
35	Special Cost Centers	304,068	35
36	Provider Participation Fee	123,482	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,632,451	40
41	Income before Income Taxes (line 30 minus line 40)**	(537,923)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (537,923)	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,783,205	44
45	Private Pay - Net Inpatient Revenue	329,375	45
46	Medicare - Net Inpatient Revenue	483,035	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,595,615	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number The Clayberg Fulton County Nursing Center

0014290

Report Period Beginning: 12/1/2017

Ending: 11/30/2018

11/30/2018

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	2,080	2,080	\$ 64,644	\$ 31.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,549	10,609	299,606	28.24	3
4	Licensed Practical Nurses	10,033	10,731	245,956	22.92	4
5	CNAs & Orderlies	32,744	35,566	432,391	12.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,496	8,533	113,403	13.29	8
9	Activity Director	1,763	1,974	34,040	17.24	9
10	Activity Assistants	5,066	5,671	65,256	11.51	10
11	Social Service Workers	1,750	2,016	42,832	21.25	11
12	Dietician					12
13	Food Service Supervisor	1,747	2,022	45,251	22.38	13
14	Head Cook	8,353	8,864	113,772	12.84	14
15	Cook Helpers/Assistants	8,980	9,562	103,148	10.79	15
16	Dishwashers					16
17	Maintenance Workers	3,369	3,918	67,346	17.19	17
18	Housekeepers	13,694	15,158	157,609	10.40	18
19	Laundry					19
20	Administrator	2,080	2,080	81,079	38.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	58,913	28.32	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,884	2,146	57,167	26.64	32
33	Other(specify)	1,442	1,655	27,847	16.83	33
34	TOTAL (lines 1 - 33)	114,110	124,665	\$ 2,010,260 *	\$ 16.13	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	96	\$ 4,167	1-3	35
36	Medical Director		250	9-3	36
37	Medical Records Consultant		3,517	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,236	39-3	39
40	Physical Therapy Consultant	921	72,373	39-3	40
41	Occupational Therapy Consultant	1,266	69,094	39-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	864	23,025	39-3	43
44	Activity Consultant	48	3,567	11-3	44
45	Social Service Consultant				45
46	Other(specify) <u>Radiology</u>		1,444	43-3	46
47	<u>Lab</u>		2,483	43-3	47
48					48
49	TOTAL (lines 35 - 48)	3,195	\$ 185,156		49

C. CONTRACT NURSES

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

Facility Name & ID Number The Clayberg Fulton County Nursing Center# 0014290Report Period Beginning: 12/1/2017Ending: 11/30/2018**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. IHCA \$3,234
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,610 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 123,482
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? Yes Indicate the amount. \$ 4,304
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? 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: Gray Hunter Stenn LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Page 3, line 27	Marketing Director	\$ 27,847
Page 4, line 43	Radiology	\$ 2,483
	Laboratory	<u>1,444</u>
		3,927
Page 14, line 16	Dishwasher \$74/month	\$ 888
	1 Copier \$262.38/month Dec 2017-April 2018	1,312
	2 Copiers \$418/month May 2018-Dec 2018	<u>2,926</u>
		5,126
Page 19, line 28	Property Taxes	\$ 477,703
Page 19, line 28A	Misc. Reimbursements	\$ 4,781