FOR BHF USE

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2021
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2021)

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

I. IDPH License ID Number: 0008409

Facility Name: Alton Memorial Rehab Therapy

Address: 1251 College Avenue (Number) Alton (City) 62002 (Zip Code)

County: Madison

Telephone Number: (618) 463-7330 **Fax #** (618) 463-7850

HFS ID Number:

Date of Initial License for Current Owners: 12/30/1966

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kevin Wellen, CPA **Telephone Number:** (314) 925-4300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2021 to 12/31/2021 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kevin Wellen, CPA, Signing Director
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Ave, Ste. 1800, St. Louis, MO 63101
(Telephone) (314) 925-4300 Fax # (314) 925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	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	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,414	6,021	8,857	16,292	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,414	6,021	8,857	16,292	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.74%

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)
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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/30/1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 5,212

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2021 Fiscal Year: 12/31/2021

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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary			287,242	287,242		287,242	230,616	517,858			1
2	Food Purchase		296,641		296,641		296,641	229,599	526,240			2
3	Housekeeping	140,285	18,810	3,556	162,651		162,651		162,651			3
4	Laundry		11,818	44,202	56,020		56,020		56,020			4
5	Heat and Other Utilities			126,074	126,074		126,074		126,074			5
6	Maintenance	52,481	24,857	167,072	244,410		244,410		244,410			6
7	Other (specify):*											7
8	TOTAL General Services	192,766	352,126	628,146	1,173,038		1,173,038	460,215	1,633,253			8
	B. Health Care and Programs											
9	Medical Director					23,000	23,000		23,000			9
10	Nursing and Medical Records	1,794,550	89,245	498,361	2,382,156		2,382,156		2,382,156			10
10a	Therapy											10a
11	Activities	82,730	2,178	700	85,608	3,419	89,027		89,027			11
12	Social Services	47,092	78	73	47,243	3,418	50,661		50,661			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,924,372	91,501	499,134	2,515,007	29,837	2,544,844		2,544,844			16
	C. General Administration											
17	Administrative	115,159			115,159		115,159		115,159			17
18	Directors Fees											18
19	Professional Services			568,498	568,498	(29,837)	538,661		538,661			19
20	Dues, Fees, Subscriptions & Promotions			46,388	46,388		46,388	(11,079)	35,309			20
21	Clerical & General Office Expenses	270,486	127,169	14,372	412,027		412,027	(5,225)	406,802			21
22	Employee Benefits & Payroll Taxes			621,480	621,480		621,480		621,480			22
23	Inservice Training & Education			2,898	2,898		2,898		2,898			23
24	Travel and Seminar			675	675		675		675			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			131,875	131,875		131,875		131,875			26
27	Other (specify):*											27
28	TOTAL General Administration	385,645	127,169	1,386,186	1,899,000	(29,837)	1,869,163	(16,304)	1,852,859			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,502,783	570,796	2,513,466	5,587,045		5,587,045	443,911	6,030,956			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 Alton Memorial Rehab Therapy #0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			67,431	67,431		67,431	81,783	149,214			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			(20,941)	(20,941)		(20,941)		(20,941)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			57,755	57,755		57,755		57,755			35
36	Other (specify):*											36
37	**TOTAL Ownership**			104,245	104,245		104,245	81,783	186,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		305,923	767,314	1,073,237		1,073,237		1,073,237			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,009	61,009		61,009		61,009			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		305,923	828,323	1,134,246		1,134,246		1,134,246			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,502,783	876,719	3,446,034	6,825,536		6,825,536	525,694	7,351,230			45

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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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				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	(9,220)	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	(8,101)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (17,321)		$	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 Amount	2 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)	543,015		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 543,015		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 525,694		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 Yes	2 No	3 Amount	4 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	**TOTAL (C): (sum of lines 38-46)**			$		47

Alton Memorial Rehab Therapy

ID# 0008409

Report Period Beginning: 1/1/2021

Ending: 12/31/2021

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,017)	2	1
2	Misc Income	(1,083)	21	2
3	Lost Personal Property	(4,142)	21	3
4	Lobbying Portion of IHCA dues	(1,859)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,101)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	230,616	0	0	0	0	0	0	0	0	0	230,616	1
2	Food Purchase	(1,017)	230,616	0	0	0	0	0	0	0	0	0	229,599	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,017)	461,232	0	0	0	0	0	0	0	0	0	460,215	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,079)	0	0	0	0	0	0	0	0	0	0	(11,079)	20
21	Clerical & General Office Expenses	(5,225)	0	0	0	0	0	0	0	0	0	0	(5,225)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(16,304)	0	0	0	0	0	0	0	0	0	0	(16,304)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(17,321)	461,232	0	0	0	0	0	0	0	0	0	443,911	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	81,783	0	0	0	0	0	0	0	0	0	81,783	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	81,783	0	0	0	0	0	0	0	0	0	81,783	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(17,321)	543,015	0	0	0	0	0	0	0	0	0	525,694	45

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary Services	$ 287,242	BJC - Alton Memorial Hospital		$ 517,858	$ 230,616	1
2	V	2	Food	287,242	BJC - Alton Memorial Hospital		517,858	230,616	2
3	V	19	IT	4,676	BJC Healthcare	100.00%	4,676		3
4	V	39	Ancillary Services	14,611	BJC Healthcare	100.00%	14,611		4
5	V	30	Depreciation		BJC - Alton Memorial Hospital (Dietary Capital Costs)		81,783	81,783	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			$ 593,771			$ 1,136,786	$ * 543,015	14

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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Gary Ayres	BOD						1
2	Stephen Thompson	BOD						2
3	George Milnor	BOD						3
4	David Braasch	BOD						4
5	April Becker	BOD						5
6	Nick Barto	BOD						6
7	Melissa Erker	BOD						7
8	Joan Magruder	BOD						8
9	Shelia Goins	BOD						9
10	Bruce Hartrich	BOD						10
11	Gaye Julian	BOD						11
12	Sandra Lauschke	BOD						12
13	Kenneth Loy	BOD						13
14	Edward Ryrie	BOD						14
15	Dr. Geoffrey Turner	BOD						15
16	Kenneth Balsters	BOD						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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 2/31/2021

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2020 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 20,941	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).		$ (20,941)	3
4. Real Estate Tax accrual used for 2021 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.		$ (20,941)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2016	19,135	8
	2017	19,523	9
	2018	19,802	10
	2019	20,343	11
	2020		12

Facility was exempt from property tax in 2021.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2020	$	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.

2020 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alton Memorial Rehab Therapy COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0008409

CONTACT PERSON REGARDING THIS REPORT Roger Byrne

TELEPHONE (314) 800-1956 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2020 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 2020.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-1-07-12-12-201-009	PT SE NE PART SW NE	$	$
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 X NO

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

C. **Tax Bills**

Attach copies of the original 2020 tax bills which were listed in Section A to this statement. Be sure to use the 2020 tax bill which is normally paid during 2021.

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.

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,234 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1966	1966	$ 433,793	$	40	$	$	$ 433,793	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1966 ADDITIONS			1966	524,918		Various			524,918	9
10	1968 ADDITIONS			1968	1,049		Various			1,049	10
11	1980 ADDITIONS			1980	3,880		Various			3,880	11
12	1981 ADDITIONS			1981	40,133		Various			40,133	12
13	1983 ADDITIONS			1983	8,868		Various			8,868	13
14	1985 ADDITIONS			1985	7,208		Various			4,208	14
15	1990 ADDITIONS			1990	27,998		Various			27,998	15
16	1991 ADDITIONS			1991	12,575		Various			12,575	16
17	1992 ADDITIONS			1992	30,291		Various			30,291	17
18	1993 ADDITIONS			1993	68,589		Various			68,589	18
19	1994 ADDITIONS			1994	12,883		Various			12,883	19
20	1995 ADDITIONS			1995	82,542		Various			82,542	20
21	1996 ADDITIONS			1996	9,373		Various			9,373	21
22	1997 ADDITIONS			1997	39,454		Various			39,454	22
23	1998 ADDITIONS			1998	28,092		Various			28,092	23
24	1999 ADDITIONS			1999	16,822		Various			16,822	24
25	2001 ADDITIONS			2001	193,922	7,757	Various	7,757		193,922	25
26	2003 ADDITIONS			2003	197,646		Various			197,646	26
27	2004 ADDITIONS			2004	189,766		Various			189,766	27
28	2005 ADDITIONS			2005	62,559	146	Various	146		62,559	28
29	2007 ADDITIONS			2007	12,156		Various			12,156	29
30	2008 ADDITIONS			2008	35,700		Various			35,700	30
31	2009 ADDITIONS			2009	66,272		Various			66,272	31
32	2011 ADDITIONS			2011	5,500	275	Various	275		5,500	32
33	2012 ADDITIONS			2012	23,597	2,360	10	2,360		23,597	33
34	HVAC			2013	12,800	1,280	10	1,280		12,800	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ESH Bathroom/Shower	2014	$ 30,665	$ 3,067	10	$ 3,067	$	$ 23,131	37
38	ESH Fire Alarm Panel	2014	15,741	1,574	10	1,574		11,421	38
39	Submersible Power unit/Shut Off Valve/ISO Coupling Machine	2015	17,401	1,740	10	1,740		11,311	39
40	Patching Parking Lot	2015	12,450		5			12,450	40
41	PTAC (Heating/Cooling Units) (40	2015	70,332	4,689	15	4,689		28,133	41
42	Fountain & Walk	2016	11,796	590	20	590		11,796	42
43	Rebuild Walk In Cooler	2017	13,535	902	15	902		4,060	43
44	Heating/Cooling Units for Rooms	2017	60,240	6,023	10	6,023		27,103	44
45	Generator	2018	42,312	2,116	20	2,116		7,405	45
46	Parking Lot Resurfacing	2018	34,000	4,250	8	4,250		12,396	46
47	Pump & Motor Assembly	2020	3,942	493	8	493		3,942	47
48	AC Units (5)	2021	7,245	725	5	725		725	48
49	Booster Heater - Replacement	2021	3,165	158	10	158		158	49
50	Parking Lot and Stripping - Asphalt	2021	34,750	2,172	8	2,172		2,172	50
51	Alton Memorial Hospital Depreciation (Dietary)			81,783		81,783			51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,505,959	$ 122,100		$ 122,100	$	$ 2,301,589	70

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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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	$ 244,590	$ 24,806	$ 24,806	$		$ 65,938	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	503,782	2,308	2,308			503,782	73
74								74
75	TOTALS	$ 748,372	$ 27,114	$ 27,114	$		$ 569,720	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	Bus	2011 Ford E450	2011	$ 51,305	$	$	$	10	$ 51,305	76
77										77
78										78
79										79
80	TOTALS			$ 51,305	$	$	$		$ 51,305	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)	$ 3,305,636	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 149,214	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,214	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)	$ 2,922,614	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.

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2022	$
13.	/2023	$
14.	/2024	$

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: $ 57,755 Description: Nursing equipment, copier, storage
(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

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

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

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V39-2 & V39-3	hrs	$	5,449	$ 282,886	$ 5,625	5,449	$ 288,511	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		2,031	99,708		2,031	99,708	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-2 & V39-3	hrs		6,492	285,957	7,007	6,492	292,964	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				293,291		293,291	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Radiology/Laboratory	V39-3				98,763			98,763	12
13	Other (specify):									13
14	TOTAL			$	13,972	$ 767,314	$ 305,923	13,972	$ 1,073,237	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 Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 310,479	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 26,988)	678,989		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,219		7
8	Accounts Receivable (owners or related parties)	(6,826)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 996,861	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,071,056		14
15	Leasehold Improvements, at Historical Cost	285,061		15
16	Equipment, at Historical Cost	1,949,519		16
17	Accumulated Depreciation (book methods)	(2,922,614)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 383,022	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,379,883	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 182,486	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER ACCRUED EXP	(376,422)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (193,936)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (193,936)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,573,819	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,379,883	$	48

*(See instructions.)

Facility Name & ID Number Alton Memorial Rehab Therapy # 0008409 Report Period Beginning: 1/1/2021 Ending: 12/31/2021

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,073,280	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,073,280	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(65,036)	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) **Prior Period Adjustment**	(434,425)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (499,461)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,573,819	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,381,823	1
2	Discounts and Allowances for all Levels	(2,284,626)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,097,197	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,987,059	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,987,059	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	553,490	17
18	Sale of Supplies to Non-Patients	112,393	18
19	Laboratory	(900)	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 664,983	23
	D. Non-Operating Revenue		
24	Contributions	1,116	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,116	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER REVENUE	10,145	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,145	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,760,500	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,173,038	31
32	Health Care	2,515,007	32
33	General Administration	1,899,000	33
	B. Capital Expense		
34	Ownership	104,245	34
	C. Ancillary Expense		
35	Special Cost Centers	1,073,237	35
36	Provider Participation Fee	61,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,825,536	40
41	**Income before Income Taxes (line 30 minus line 40)****	(65,036)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (65,036)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 232,707	44
45	Private Pay - Net Inpatient Revenue	983,044	45
46	Medicare - Net Inpatient Revenue	417,755	46
47	Other-(specify) MANAGED CARE	463,691	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,097,197	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	8,322	8,322	$ 308,905	$ 37.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,705	6,705	265,078	39.53	3
4	Licensed Practical Nurses	13,567	13,567	404,785	29.84	4
5	CNAs & Orderlies	40,636	40,636	815,782	20.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,599	4,599	82,730	17.99	9
10	Activity Assistants					10
11	Social Service Workers	2,186	2,186	47,092	21.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,084	2,084	52,481	25.18	17
18	Housekeepers	9,941	9,941	140,285	14.11	18
19	Laundry					19
20	Administrator	2,080	2,080	115,159	55.36	20
21	Assistant Administrator					21
22	Other Administrative	14,201	14,201	270,486	19.05	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,321	104,321	$ 2,502,783 *	$ 23.99	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	23,000	V09-4	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,419	V11-4	44
45	Social Service Consultant		3,418	V12-4	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,837		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	450	$ 25,620	V10-3	50
51	Licensed Practical Nurses	4,681	321,218	V10-3	51
52	Certified Nurse Assistants/Aides	2,852	92,012	V10-3	52
53	TOTAL (lines 50 - 52)	7,983	$ 438,850		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Renee Cwiklowski	Administrator	0	$ 13,177
Mark Jeffries	VP & Administrator LTC	0	101,982
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,159

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bethesda Health Group	Management Fee	$ 404,017
Bethesda Health Group	Technology Services	108,148
Accurate Biometrics, Inc	Fingerprinting/Background Che	370
Outcome Services	Social Svs/Activities	6,837
BJC	IT	4,676
Generation Medical	Medical Director	23,000
Illinois State Police	Background Checks	3,490
Iron Mountain/Shred-It	Offsite Storage/Shredding	3,591
National Datacare Corporation	Business Office	7,667
IL Dept of Public Health	Professional Services	(770)
Various - Temp Staffing	Professional Services	7,472
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 568,498

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,223
Unemployment Compensation Insurance	13,715
FICA Taxes	152,351
Employee Health Insurance	259,349
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Medicare Taxes	35,630
TSA Pension	33,451
Life and Disability	18,414
Other Incentives	10,070
Tuition Reimbursement	6,277
TOTAL (agree to Schedule V, line 22, col.8)	$ 621,480

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,156
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Public Relations	9,220
Subscriptions/Dues	12,509
Leading Age Dues	6,229
Less: Lobbying Portion	(1,859)
Licenses & Permits	3,274
Less: Public Relations Expense	(9,220)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,309

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	675
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 675

**See instructions.

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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. **Leading Age - Illinois $6,228.97**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **N/A**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,057** 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. $ **61,009**
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. $ **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? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees