

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 23952 Facility Name: Apostolic Christian Restmor Address: 1500 Parkside Dr Morton 61550 County: Tazewell Telephone Number: 309-284-1400 Fax # 309-266-7877 HFS ID Number: Date of Initial License for Current Owners: 4/1/1978 Type of Ownership: VOLUNTARY,NON-PROFIT X Charitable Corp. Trust IRS Exemption Code 501-c-3 PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Michael Kaiser Telephone Number: 309-284-1402 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 01/01/2011 to 12/31/2011 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) (Type or Print Name) John Kelley (Title) Administrator Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) () Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Apostolic Christian Restmor

23952 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>116</u>	Skilled (SNF)	<u>116</u>	<u>42,340</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>12</u>	Sheltered Care (SC)	<u>12</u>	<u>4,380</u>	5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,720</u>	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	<u>3,292</u>	<u>26,953</u>	<u>3,433</u>	<u>33,678</u>	8
9	SNF/PED					9
10	ICF	<u>730</u>	<u>5,868</u>		<u>6,598</u>	10
11	ICF/DD					11
12	SC	<u>3,107</u>			<u>3,107</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,129</u>	<u>32,821</u>	<u>3,433</u>	<u>43,383</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.86%

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

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

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

meals on wheels

F. Does the facility maintain a daily midnight census?

yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started

04/1/2008

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

42

and days of care provided

3,433

Medicare Intermediary Wisconsin Physicians Ins Co

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31

Fiscal Year: 12/31

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

Facility Name & ID Number Apostolic Christian Restmor # 23952 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	463,706	42,639	43,189	549,534		549,534		549,534			1
2	Food Purchase		328,019		328,019	(8,692)	319,327	(25,621)	293,706			2
3	Housekeeping	134,296	52,224		186,520		186,520		186,520			3
4	Laundry	96,674	12,134		108,808		108,808		108,808			4
5	Heat and Other Utilities			217,674	217,674		217,674		217,674			5
6	Maintenance	176,577	40,482	276,832	493,891	(10,623)	483,268		483,268			6
7	Other (specify):*			22,864	22,864		22,864		22,864			7
8	TOTAL General Services	871,253	475,498	560,559	1,907,310	(19,315)	1,887,995	(25,621)	1,862,374			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	3,712,185	233,896	5,593	3,951,674		3,951,674		3,951,674			10
10a	Therapy			397,937	397,937		397,937		397,937			10a
11	Activities	160,983	2,933		163,916		163,916	(86)	163,830			11
12	Social Services	178,643			178,643		178,643		178,643			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,051,811	236,829	409,030	4,697,670		4,697,670	(86)	4,697,584			16
	C. General Administration											
17	Administrative	230,318			230,318		230,318	(34,800)	195,518			17
18	Directors Fees											18
19	Professional Services			51,818	51,818		51,818	(924)	50,894			19
20	Dues, Fees, Subscriptions & Promotions			44,682	44,682	6,698	51,380	(30,392)	20,988			20
21	Clerical & General Office Expenses	264,845	14,690	142,851	422,386	(43,952)	378,434	(5,285)	373,149			21
22	Employee Benefits & Payroll Taxes			1,351,407	1,351,407	8,692	1,360,099	(12,107)	1,347,992			22
23	Inservice Training & Education											23
24	Travel and Seminar			28,790	28,790		28,790	(10,486)	18,304			24
25	Other Admin. Staff Transportation			5,729	5,729		5,729	(3,729)	2,000			25
26	Insurance-Prop.Liab.Malpractice			81,433	81,433		81,433		81,433			26
27	Other (specify):*											27
28	TOTAL General Administration	495,163	14,690	1,706,710	2,216,563	(28,562)	2,188,001	(97,723)	2,090,278			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,418,227	727,017	2,676,299	8,821,543	(47,877)	8,773,666	(123,430)	8,650,236			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			547,569	547,569		547,569		547,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,537	110,537		110,537	(8,791)	101,746			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					47,877	47,877		47,877			35
36	Other (specify):*											36
37	TOTAL Ownership			658,106	658,106	47,877	705,983	(8,791)	697,192			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			184,416	184,416		184,416		184,416			39
40	Barber and Beauty Shops	35,465		4,070	39,535		39,535		39,535			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,465	187,465		187,465		187,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	35,465		375,951	411,416		411,416		411,416			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,453,692	727,017	3,710,356	9,891,065		9,891,065	(132,221)	9,758,844			45

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

VI. ADJUSTMENT DETAIL

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

	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				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)	\$		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$		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

ID#

23952

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non allowable seminar	\$ (2,860)	24	1
2	Non allowable dues and subscriptions	(9,989)	20	2
3	Promotion	(20,398)	20	3
4	Employee meal income	(8,622)	22	4
5	Guest meal income	(2,726)	2	5
6	Misc Expense	(325)	21	6
7	Misc income	(4,364)	21	7
8	Auto expense	(3,729)	25	8
9	Professional fees	(924)	19	9
10	Meals on wheels	(22,895)	2	10
11	Sunshine cart income	(86)	11	11
12	ILU Management fee	(34,800)	17	12
13	Travel out of Illinois	(7,626)	24	13
14	Penalties	(5)	20	14
15	Interest income	(3,485)	22	15
16	Other interest income	(8,791)	32	16
17	Finance charge	(596)	21	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	(132,221)		49

Summary B

12/31/2011

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

[illegible]

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
Marty Rollins	0			The Parkside of Morto	Morton	Congregate Living
Joe Zimmerman	0					
Fred Kaiser	0					
Greg Kaiser	0					
Bruce Sauder	0					

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

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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	Marty Rollins	BOD						1
2	Joe Zimmerman	BOD						2
3	Fred Kaiser	BOD						3
4	Greg Kaiser	BOD						4
5	Bruce Sauder	BOD						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

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									\$		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 Apostolic Christian Restmor # 23952 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 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

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**		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	Morton Community Bank		X	Building Mortgage	\$16,567.00	06/01/2011	\$ 1,770,000	\$ 913,497	05/16/2016	5.0000	\$ 110,537	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$16,567.00		\$ 1,770,000	\$ 913,497			\$ 110,537	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,770,000	\$ 913,497			\$ 110,537	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2011 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:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		12		

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,000

B. General Construction Type: Exterior Brick Frame Stick 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).

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

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility Site	849,420		\$ 327,810	1
2	Vacant Land	435,600		75,000	2
3	TOTALS	1,285,020		\$ 402,810	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	128		2008	2008	\$ 15,081,596	\$ 377,040	40	\$ 377,040	\$	\$ 1,413,900	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Site preparation and grading			2008	395,786						9
10	Remote unattached storage building			2008	207,121	5,178	40	5,178		19,418	10
11	Road and parking area			2008	194,661	9,733	20	9,733		36,499	11
12	Brick Edging and Landscaping			2008	10,923	546	20	546		1,960	12
13	New Sidewalk			2009	8,245	550	15	550		1,283	13
14	Concrete drainage ways for stormwater			2009	10,656	533	20	533		1,154	14
15	Additional Heat Pump for Spa area			2009	7,020	468	15	468		1,248	15
16	Additional Lighting			2009	9,232	615	15	615		1,640	16
17	New Ventilators in Spa area			2009	6,791	453	15	453		1,178	17
18	Additional Smoke Devices			2009	2,667	178	15	178		504	18
19	Additional Door Holders			2009	2,758	184	15	184		429	19
20	Courtyard concrete finish			2010	11,808	590	20	590		1,033	20
21	Re keying all doors			2010	9,980	270	37	270		450	21
22	Smokedoors			2010	10,570	286	37	286		453	22
23	New Trees			2010	5,000	135	37	135		169	23
24	New Trees			2011	3,900	36	36	36		36	24
25	Linoleum in laundry room			2011	7,667	532	12	532		532	25
26	Paneling in patient rooms			2011	9,550	464	12	464		464	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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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)		\$ 15,995,931	\$ 397,791		\$ 397,791	\$	\$ 1,482,350	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	\$1,752,967	\$139,697	\$139,697	\$	4--15	\$669,696	71
72	Current Year Purchases	56,916	4,310	4,310		4--10	4,310	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,809,883	\$144,007	\$144,007	\$		\$674,006	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 Transp	1996 Dodge Van	1996	\$21,621	\$	\$	\$		\$21,621	76
77	Staff Transp	Chevy Ventur Van	1998	24,913					24,913	77
78	Machinery	mowing		8,720					8,720	78
79	Patient Transp	Chvy Ex Pass; Chvy Braun	2010-2011	56,649	5,771	5,771		7	6,633	79
80	TOTALS			\$111,903	\$5,771	\$5,771	\$		\$61,887	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)	\$18,320,527	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$547,569	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$547,569	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)	\$2,218,243	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	ILU land	\$25,652	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$25,652	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$47,877
- Description:several large copiers and a bus used for resident outings
- (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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$		\$ 42,922	\$		\$ 42,922	1
2	Licensed Speech and Language Development Therapist	10a	hrs			84,989			84,989	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs			43,036			43,036	4
5	Physician Care	39	visits			923			923	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts			137,058			137,058	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): lab	39				46,435			46,435	12
13	Other (specify):									13
14	TOTAL			\$		\$ 355,363	\$		\$ 355,363	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.

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	\$ 1,162,447	\$	1
2	Cash-Patient Deposits	8,806		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	677,236		3
4	Supply Inventory (priced at)	78,396		4
5	Short-Term Investments	1,809,402		5
6	Prepaid Insurance	122,902		6
7	Other Prepaid Expenses	21,806		7
8	Accounts Receivable (owners or related parties)	23,070		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,904,065	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	402,810		13
14	Buildings, at Historical Cost	15,081,596		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,921,785		16
17	Accumulated Depreciation (book methods)	(2,218,243)		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):	856,711		22
23	Other(specify):	83,276		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,127,935	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 20,032,000	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 233,370	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,806		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	554,668		30
31	Accrued Taxes Payable (excluding real estate taxes)	131,713		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	<u>accrued pension</u>	341,617		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,270,174	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	913,497		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)	\$ 913,497	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,183,671	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,848,329	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 20,032,000	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,835,539	1
2	Restatements (describe):		2
3	voided check	154	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,835,693	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,012,636	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)	\$ 2,012,636	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)	\$ 17,848,329	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,947,497	1
2	Discounts and Allowances for all Levels	(612,549)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,334,948	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	765,768	6
7	Oxygen	61,783	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 827,551	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	51,807	13
14	Non-Patient Meals	32,546	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	123,218	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,866	19
20	Radiology and X-Ray		20
21	Other Medical Services	286,838	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 517,275	23
	D. Non-Operating Revenue		
24	Contributions	1,166,574	24
25	Interest and Other Investment Income***	12,276	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,178,850	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc income	4,150	28
28a	page24	40,927	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45,077	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,903,701	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,907,310	31
32	Health Care	4,697,670	32
33	General Administration	2,216,563	33
	B. Capital Expense		
34	Ownership	658,106	34
	C. Ancillary Expense		
35	Special Cost Centers	223,951	35
36	Provider Participation Fee	187,465	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,891,065	40
41	Income before Income Taxes (line 30 minus line 40)**	2,012,636	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,012,636	43

* 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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,824	1,964	\$74,007	\$37.68	1
2	Assistant Director of Nursing	2,136	2,349	76,067	32.38	2
3	Registered Nurses	38,608	41,933	1,030,891	24.58	3
4	Licensed Practical Nurses	21,348	23,585	535,769	22.72	4
5	CNAs & Orderlies	114,283	123,889	1,671,923	13.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,843	4,385	68,949	15.72	8
9	Activity Director	1,811	1,965	26,396	13.43	9
10	Activity Assistants	10,715	11,432	134,587	11.77	10
11	Social Service Workers	5,069	5,513	98,976	17.95	11
12	Dietician	2,142	2,270	49,743	21.91	12
13	Food Service Supervisor					13
14	Head Cook	4,868	5,322	76,309	14.34	14
15	Cook Helpers/Assistants	28,042	30,675	337,654	11.01	15
16	Dishwashers					16
17	Maintenance Workers	8,738	9,421	176,577	18.74	17
18	Housekeepers	10,677	11,537	134,296	11.64	18
19	Laundry	7,975	8,967	96,674	10.78	19
20	Administrator	1,840	2,080	122,773	59.03	20
21	Assistant Administrator	1,952	2,200	107,545	48.88	21
22	Other Administrative	3,522	3,979	79,667	20.02	22
23	Office Manager					23
24	Clerical	10,757	11,865	245,250	20.67	24
25	Vocational Instruction					25
26	Academic Instruction	1,820	2,080	75,508	36.30	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	8,567	9,357	127,635	13.64	31
32	Other Health Care: Dementia Dir	2,032	2,413	51,436	21.32	32
33	Other(specify) Vol; Hair care	2,887	3,145	55,060	17.51	33
34	TOTAL (lines 1 - 33)	295,456	322,326	\$5,453,692 *	\$16.92	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$5,500	9-3	35
36	Medical Director				36
37	Medical Records Consultant	40	2,761	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	\$8,261		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
			\$
John Kelley	Administrator	0	122,773
Michael Kaiser	Asst Adm	0	107,545
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 230,318
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
Clifton Gunderson	Accounting		\$ 30,225
Heinold Banwart	Accounting		2,000
FGMK	Consulting		1,789
Frost Ruttenberg & Rothblatt	Consulting		2,856
Principle Financial Group	Pension Plan Adm		11,544
Personell Planners	U/C adm		1,428
Go To My PC	Internet Adm		1,052
Benckendorf & Benckendorf	Legal		924
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 51,818
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	116,501
Unemployment Compensation Insurance			27,380
FICA Taxes			397,234
Employee Health Insurance			416,756
Employee Meals			70
Illinois Municipal Retirement Fund (IMRF)*			
Employee health services			10,305
Employee relations			8,971
Pension Expense			331,801
Uniform Rental			9,406
Hiring and Training			6,638
Dental Ins			13,595
Tuition reimbursement			9,335
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,347,992
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			6,698
Health Care Worker Background Check (Indicate # of checks performed 45)			1,350
Patient Background Checks 79			790
State Association Dues			8,278
Other dues and fees			3,872
Less: Public Relations Expense ()			
Non-allowable advertising ()			
Yellow page advertising ()			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 20,988
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			6,932
Seminar Expense			11,372
Entertainment Expense ()			
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	18,304

*** Attach copy of IMRF notifications**

****See instructions.**

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.

LSN 8278

(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?

What was the average life used for new equipment added during this period?

yes

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 53,892

Line 10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

(9)

Are you presently operating under a sublease agreement?

YES

x

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

x

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 187,465

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.

\$ 8,692

Has any meal income been offset against related costs?

yes

Indicate the amount.

\$ 8,622

(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?

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?

some

d. Have vehicle usage logs been maintained?

no

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ none

(17)

Has an audit been performed by an independent certified public accounting firm?

review

Firm Name:

clifton Larson

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE XVII PAGE 19

LINE 28a

Social activities income	2057
Private pay laundry	2150
Personal supplies income	1023
Finance charge	596
Sunshine cart income	86
Misc income	215
Independent living management	<u>34800</u>
Total	<u><u>40927</u></u>

Reconciliation for vehicles

	Cost	A/D
Per Cost Report 12/31/2010	124435	101148
Old Assets disposed of	-45033	-45033
Additions in 2011	32500	0
Depr taken in 2011	0	5771
Per Cost Report 12/31/2011	<u>111902</u>	<u>61886</u>