

		FOR BHF USE					

LL1

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: 0020495

Facility Name: Brother James Court

Address: 2508 St James Road Springfield 62707
Number City Zip Code

County: Sangamon

Telephone Number: (217) 544-4676 Fax # (217) 747-5914

HFS ID Number: 43/1588535004

Date of Initial License for Current Owners: October 1, 1975

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ 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: Mary Shade Telephone Number: (217) 747-5912
Email Address: bookkrrp2@brotherjamescourt.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/10 to 06/30/11 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) 10/31/11 (Date)
(Type or Print Name) Ron Wampler
(Title) Administrator

Paid Preparer

(Signed) (Date)
(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

Facility Name & ID Number Brother James Court

0020495 Report Period Beginning: 07/01/10 Ending: 06/30/11

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	99	Intermediate/DD	99	36,135	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,618	365	365	33,348	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,618	365	365	33,348	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.29%

D. How many bed-hold days during this year were paid by the Department? 1,020 (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) _____

F. Does the facility maintain a daily midnight census? _____

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 10/1/75

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 _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30 Fiscal Year: 6/30

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	207,191	22,081	4,864	234,136		234,136		234,136			1
2	Food Purchase		194,036		194,036		194,036		194,036			2
3	Housekeeping	55,905	20,717		76,622		76,622		76,622			3
4	Laundry	48,875	6,643		55,518		55,518		55,518			4
5	Heat and Other Utilities			145,269	145,269		145,269		145,269			5
6	Maintenance	59,276	494	59,532	119,302		119,302		119,302			6
7	Other (specify):*											7
8	TOTAL General Services	371,247	243,971	209,665	824,883		824,883		824,883			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,532,687	46,618	3,404	1,582,709		1,582,709		1,582,709			10
10a	Therapy	23,554		18,834	42,388		42,388		42,388			10a
11	Activities	32,390			32,390		32,390		32,390			11
12	Social Services	156,810	1,345	6,000	164,155		164,155		164,155			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,745,441	47,963	33,038	1,826,442		1,826,442		1,826,442			16
	C. General Administration											
17	Administrative	70,836			70,836		70,836		70,836			17
18	Directors Fees											18
19	Professional Services			17,412	17,412		17,412		17,412			19
20	Dues, Fees, Subscriptions & Promotions			6,748	6,748		6,748		6,748			20
21	Clerical & General Office Expenses	231,288	21,831	101,724	354,843		354,843	(70,837)	284,006			21
22	Employee Benefits & Payroll Taxes			513,106	513,106		513,106		513,106			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,582	62,582		62,582		62,582			26
27	Other (specify):*											27
28	TOTAL General Administration	302,124	21,831	701,572	1,025,527		1,025,527	(70,837)	954,690			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,418,812	313,765	944,275	3,676,852		3,676,852	(70,837)	3,606,015			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			161,768	161,768		161,768	104,347	266,115			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			431,768	431,768		431,768	(165,653)	266,115			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			230,720	230,720		230,720		230,720			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			230,720	230,720		230,720		230,720			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,418,812	313,765	1,606,763	4,339,340		4,339,340	(236,490)	4,102,850			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	(70,837)	21		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)	\$ (70,837)		\$	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)	(165,653)	34,30	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (165,653)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (236,490)		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

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/10

Ending: 06/30/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary B

06/30/11

[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
N/A		N/A		Franciscan Brothers of Springfield	Springfield	
				Springfield Developme	Springfield	
				Weber Care Corp.	Springfield	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	\$ 270,000	Franciscan Brothers of Holy Cross	100.00%	\$	(270,000)	1
2	V	30	Depreciation		Franciscan Brothers of Holy Cross	100.00%	104,347	104,347	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			\$ 270,000			\$ 104,347	\$ * (165,653)	14

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brother Gerald Voycheck	Staff Trainer		None	0			Consultant	\$ 935	21,1	1
2	Brother Anothy Joseph McCoy	Mission Effectiveness		None	0			Consultant	17,520	21,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,455		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 Brother James Court # 0020495 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

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

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							\$					\$	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.)

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

FACILITY NAME	<u>Brother James Court</u>	COUNTY	<u>Sangamon</u>
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,210

B. General Construction Type: Exterior Brick/Stone Frame Steel Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1975	1975	\$ 1,003,250	\$	30	\$	\$	\$ 1,003,250	4
5			1996	1996	1,251,493		30	41,716	41,716	604,888	5
6			1997	1997	1,256,490		30	41,883	41,883	549,128	6
7											7
8											8
	Improvement Type**										
9	NEW WING-HEATING AND AIR CONDITIONING			1997	18,883		30	629	629	8,549	9
10	REPAVE PARKING LOT			1986	42,236		10			42,236	10
11	PAINTING/DECORATING			1979	2,591		5			2,591	11
12	BJC-BLDG IMPROVEMENTS			1980	16,233		11			16,233	12
13	BJC-BLDG IMPROVEMENTS			1984	21,419		10			21,419	13
14	BJC-REMODELING			1987	69,555		10			69,555	14
15	BJC-WATER LINE			1987	14,120		20			14,120	15
16	INSULATION			1991	9,175		15			9,175	16
17	ELECTRICAL REPAIR			1991	613		10			613	17
18	BOILER TANK REMOVAL			1992	12,498		20	625	625	11,764	18
19	TANK ROVEAL			1992	8,500		10			8,500	19
20	DISHWASHING ROOM SEWER			1992	10,680		20			8,544	20
21	BJC-STEAM LINE			1985	14,479		10			14,479	21
22	BJC-BLDG IMPROVEMENTS			1975	19,600		24			19,600	22
23	BJC-DINING AREA REMODELING			1976	34,951		10			34,951	23
24	BJC-SIDEWALK/PATIO			1976	3,545		10			3,545	24
25	BJC-BIKE RINK			1978	2,500		50			2,500	25
26	BJC-AIR CONDITIONING SYSTEM			1979	22,876		10			22,876	26
27	BJC-SITE IMPROVEMENT			1979	1,440		26			1,440	27
28	ROOF			1979	12,166		10			12,166	28
29	ROOFING			1986	45,811		10			45,811	29
30	REMODELING			1988	46,656		10			46,656	30
31	WATER LINE			1989	3,166		20			3,166	31
32	SEWAGE TREATMENT PLANT			1990	6,411		20	107	107	6,411	32
33	TANK ROVEAL			1991	9,809		10			9,809	33
34	PARKING LOT			1992	10,452		10			10,452	34
35	PAINT RESTROOMS			1992	230		5			230	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 Brother James Court

0020495

Report Period Beginning:

07/01/10

Ending:

06/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BOILER ROOM REMODELING	1993	\$ 15,106	\$	20	\$ 755	\$ 755	\$ 13,224	37
38	REPAVE PARKING LOT	1994	850		10			850	38
39	PUMP	1994	734		10			734	39
40	AIRCONDITIONER WORK	1994	943		10			943	40
41	BOILER ROOM PROJECT	1994	170,330		20	8,517	8,517	139,313	41
42	LAND IMPROVEMENT - TREES	1996	3,470		20	174	174	2,487	42
43	BJC-BLDG IMPROVEMENTS	1998	15,712		30	524	524	6,721	43
44	WATER LINE REPAIR	1999	3,102		10	233	233	3,335	44
45	LAND IMPROVEMENT - TREES	1999	25,849		20	1,292	1,292	13,786	45
46	GATE	1999	550		5			550	46
47	REMODELING	1999	5,773		10	530	530	6,303	47
48	FLOOR	2000	1,683		7			1,683	48
49	TOTAL LIFE CENTER	1998	122,261		30	4,075	4,075	51,281	49
50	PARKIGLOTBLACKTOP	2000	49,310		15	3,287	3,287	35,337	50
51	LEASEHOLD IMPROVEMENTS	1985	15,200		10			15,200	51
52	LEASEHOLD IMPROVEMENTS	1986	19,507		10			19,507	52
53	PAINTING	1987	9,922		3			9,922	53
54	STEEL DOOR	1987	6,020		10			6,020	54
55	WINDOW REPLACEMENT	1987	2,013		10			2,013	55
56	GENERATOR SWITCH	1988	3,335		10			3,335	56
57	REMODEL LOBBY	1989	156,996	5,233	30	5,233		112,950	57
58	BUS HUT	1989	4,715		15			4,715	58
59	WATER HEATER	1989	6,721		10			6,721	59
60	TRANSFER SWITCH	1989	1,127		10			1,127	60
61	HEAT-ENERGY PANEL	1989	8,633		10			8,633	61
62	LEASEHOLD IMPROVEMENTS	1989	6,629		10			6,629	62
63	ROOF REPAIR	1990	6,928		10			6,928	63
64	REMODELING	1990	6,953	232	30	232		4,906	64
65	OVERHEAD DOOR	1990	1,220		10			1,220	65
66	KITCHEN TANKS	1990	3,089		10			3,089	66
67	PLASTERING	1990	2,586		10			2,586	67
68	REMODEL CEILING	1990	2,970		10			2,970	68
69	LEASEHOLD IMPROVEMENTS	1990	26,015		10			26,015	69
70	TOTAL (lines 4 thru 69)		\$ 4,678,080	\$ 5,465		\$ 109,812	\$ 104,347	\$ 3,125,690	70

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/10

Ending:

06/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,678,080	\$ 5,465		\$ 109,812	\$ 104,347	\$ 3,125,690	1
2	LEASEHOLD IMPROVEMENTS	1991	2,141		10			2,141	2
3	WINDOW REPLACEMENT	1992	2,750		10			2,750	3
4	CARETERIA DOORS	1993	11,918		10			11,918	4
5	PLUMBING WORK	1994	6,858		10			6,858	5
6	PAINTING	1995	3,076		10			3,076	6
7	WALL AND DOOR REPAIR	1995	2,596		10			2,596	7
8	DOOR	1996	656		10			656	8
9	ROOF REPAIR	1996	5,985		10			5,985	9
10	PAINTING	1996	1,620		3			1,620	10
11	FURNACE	1996	502		10			502	11
12	LAND IMPROVEMENTS	1996	1,385		3			1,385	12
13	REPAIRS	1996	10,702		5			10,702	13
14	GRIP CAPS	1996	1,575		5			1,575	14
15	BOILER	1996	3,335		10			3,335	15
16	BEDDING	1996	1,505		3			1,505	16
17	AIR DEFLECTORS	1996	381		3			381	17
18	SHOWER	1996	259		5			259	18
19	SEWER	1996	9,387		10			9,387	19
20	PAINTING	1996	4,928		10			4,928	20
21	ROOF REPAIR	1997	798		10			798	21
22	DRAPES	1997	4,500		5			4,500	22
23	FLOOR COVERINGS	1997	1,722		10			1,722	23
24	DRAPES - LIFE CENTER	1997	3,153		5			3,153	24
25	FLOOR COVERING - LIFE CENTER	1997	4,422		10			4,422	25
26	PAINTING - LIFE CENTER	1997	8,917		10			8,917	26
27	FLOOR	1997	2,658		10			2,658	27
28	ALARM/SMOKE DETECTORS	1998	20,108		5			20,108	28
29	SNACK LOUNGE REMODELING	1999	2,847		5			2,847	29
30	ROOF REPAIRS	1999	846		10			846	30
31	CARPET - FRONT OFFICE	1999	8,881		5			8,881	31
32	YARD SIGNS	1999	2,825		10			2,825	32
33	NEW TEES AND VALVES	1999	11,685		10			11,685	33
34	TOTAL (lines 1 thru 33)		\$ 4,823,001	\$ 5,465		\$ 109,812	\$ 104,347	\$ 3,270,611	34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/10

Ending:

06/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,823,001	\$ 5,465		\$ 109,812	\$ 104,347	\$ 3,270,611	1
2	VINYL WALL COVERING	1999	1,127		10			1,127	2
3	SHOWER ROOM REPAIRS	1999	8,220		10			8,220	3
4	CONNECTION FEES FOR SEWER PROJECT	1998	7,438		10			7,438	4
5	TREE REMOVAL	1999	9,857		10			9,857	5
6	CONDENSOR	1999	12,396		10			12,396	6
7	LEASEHOLD IMPROVEMENTS	1999	2,598		5			2,598	7
8	LANDSCAPING	1999	18,255		10			18,255	8
9	DROP ROD ASSEMBLY	1999	6,408		10			6,408	9
10	FENCING	1999	3,840		10			3,840	10
11	TREES	1999	9,905		10			9,905	11
12	ROOF REPAIRS	2000	2,300		10			2,300	12
13	TILE FLOOR - RESIDENT WING	2000	34,740		10			34,740	13
14	PAINTING	2000	6,352		5			6,352	14
15	WINDOW REPLACEMENT	2000	2,009		10			2,009	15
16	LEASEHOLD IMPROVEMENTS	2000	5,754		5			5,754	16
17	CABINET MODIFICATIONS	1999	4,520		7			4,520	17
18	PROFESSIONAL ELECTRICAL SERVICES	1999	17,410	1,161	15	1,161		13,928	18
19	NEW SIGN FRONT	1999	900		5			900	19
20	BJC - MASONRY WORK	1999	23,465	1,564	15	1,564		18,772	20
21	PROFESSIONA; PLUMBING AND HEATING	1999	31,000	2,067	15	2,067		24,800	21
22	REMODELING	1999	19,524	1,302	15	1,302		15,620	22
23	PARKING LOT STRIPING	2000	1,549		5			1,549	23
24	PAINT BASEMENT CEILING	2000	664		5			664	24
25	DRAPERIES	2001	10,881		5			10,881	25
26	RAMP AREA DECORATING	2001	14,387		5			14,387	26
27	PAINTING AND WALLCOVERING	2001	8,058		5			8,058	27
28	AIR CURTAIN	2001	1,812		7			1,812	28
29	RECEPTICLES - BEDROOMS	2001	9,820		5			9,820	29
30	SHOWER ROOM FLOOR REPAIRS	2002	1,123	112	10	112		1,067	30
31	DOOR REPAIRS	2002	6,197	620	10	620		5,796	31
32	BOILER REPAIRS	2002	3,960		5			3,960	32
33	DRAPERIES	2002	4,200		5			4,200	33
34	TOTAL (lines 1 thru 33)		\$ 5,113,670	\$ 12,291		\$ 116,638	\$ 104,347	\$ 3,542,544	34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/10

Ending:

06/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,113,670	\$ 12,291		\$ 116,638	\$ 104,347	\$ 3,542,544	1
2	ARCHITECT FEES - REMODEL BATHROOM AREAS	2002	9,863		3			9,863	2
3	REPAVE SIDEWALKS	2002	810	81	10	81		749	3
4	TUCKPOINTING	2002	1,490	149	10	149		1,366	4
5	REPAIR FLOORS	2002	2,688	269	10	269		2,464	5
6	KEYLOCK PAD	2002	580	58	10	58		517	6
7	STRIP AND REFINISH FLOORS	2002	8,702	870	10	870		7,562	7
8	HOT WATER STORAGE TANK	2002	4,408	441	10	441		3,747	8
9	DOORS AND FRAMES	2003	3,733	373	10	373		3,079	9
10	POLE LIGHTING - WEST PARKING LOT	2004	3,740	249	15	249		1,890	10
11	SINK FAUCET AND CABINET	2004	1,133	162	7	162		1,187	11
12	WALLPAPERING/PAINTING	2004	2,358	157	15	157		1,100	12
13	DOORS AND FRAMES	2004	4,987	332	15	332		2,382	13
14	CEILING FANS	2004	1,082	155	7	155		1,108	14
15	ELECTRICAL WORK	2004	16,000	1,067	15	1,067		7,467	15
16	ALARM SYSTEM	2004	2,204	315	7	315		2,204	16
17	BOILER - KITCHEN STEAMER	2004	4,871	696	7	696		4,987	17
18	BOILER	2004	6,900	986	7	986		7,311	18
19	BOILER	2004	7,200	1,029	7	1,029		7,200	19
20	TOILET ROOM ADDITION/RENOVATION	2003	699,826	23,328	30	23,328		175,671	20
21	PARKING LOT	2004	3,443	344	30	344		2,066	21
22	HVAC LABOR/MATERIAL	2004	12,497	1,785	7	1,785		12,348	22
23	PARKING LOT	2004	74,847	2,495	30	2,495		17,257	23
24	DENTAL OFFICE RENOVATION	2004	57,955	1,932	30	1,932		13,040	24
25	POLE LIGHT REPLACEMENT	2004	1,868	267	7	267		1,779	25
26	PARKING LOT SECURITY SYSTEM	2005	20,404	2,915	7	2,915		18,938	26
27	STORAGE ROOM	2005	2,375	339	7	339		2,318	27
28	BATHROOM REPAIR	2006	4,232	846	5	846		5,008	28
29	ALARM FOR BUILDING	2006	3,000	300	10	300		1,725	29
30	ALARM FOR BUILDING	2006	3,041	304	10	304		1,698	30
31	ROOF	2006	22,370	1,118	20	1,118		6,244	31
32	WATER HEATER	2006	32,250	3,225	10	3,225		17,469	32
33	BOILER	2007	4,611	659	7	659		3,074	33
34	TOTAL (lines 1 thru 33)		\$ 6,139,138	\$ 59,537		\$ 163,884	\$ 104,347	\$ 3,887,362	34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/10

Ending:

06/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,139,138	\$ 59,537		\$ 163,884	\$ 104,347	\$ 3,887,362	1
2	BATHROOM REPAIRS	2007	6,959	994	7	994		4,639	2
3	GENERATOR	2007	2,814	563	5	563		2,580	3
4	ALARM FOR BUILDING	2007	3,325	333	10	333		1,358	4
5	NEW ROOF	2008	90,882	3,029	30	3,029		11,865	5
6	EXTERIOR FLOOD LIGHTS	2008	945	94	10	94		362	6
7	NEW HOT WATER HEATER	2009	76,900	7,930	10	7,930		20,025	7
8	A/C UNIT- NURSING STATION, BREAK ROOM	2009	36,921	4,029	10	4,029		8,469	8
9	ALARM SYSTEM UPGRADES	2009	1,240	124	10	124		279	9
10	BATHROOM RENOVATION	2009	3,346	478	7	478		956	10
11	SEAL AND STRIPE PARKING LOT	2009	3,315	474	7	474		948	11
12	REPAVING TRACK	2009	8,400	1,200	7	1,200		2,600	12
13	WING 300 BATHROOM RENOVATION	2009	44,169	5,784	7	5,784		11,568	13
14	REPAVE WALKING PATH	2009	1,450	173	7	173		346	14
15	REPAIR BRICK ON GARAGE	2009	12,330	925	10	925		1,850	15
16	REPLACE HOT & CHILLED WATER PIPING	2009	12,968	1,235	7	1,235		2,470	16
17	SEWER STATION CONSTRUCTION OF TRASH RACK	2009	15,375	1,281	7	1,281		2,562	17
18	EXTENDING MAINS TO GOOD PIPE WING 200	2009	2,787	232	7	232		464	18
19	REPAIR BOILER ROOM ROOF	2010	15,462	515	30	515		644	19
20	LIGHT FIXTURES FOR FRONT ENTRANCE	2010	4,791	958	5	958		1,118	20
21	WATER HEATER	2011	16,761	140	10	140		140	21
22	ROOF	2011	6,804	1,182	10	1,182		1,182	22
23	SEWER	2011	23,908	1,793	10	1,793		1,793	23
24	ROOF	2011	19,800	825	20	825		825	24
25	BATHROOM TILE	2011	1,200	60	10	60		60	25
26	CABINETS	2011	1,867	156	5	156		156	26
27	SIDEWALK	2011	4,169	313	10	313		313	27
28	DRAIN	2011	3,611	361	10	361		361	28
29	OUTSIDE LIGHTING	2011	4,184	767	5	767		767	29
30	DOORS	2011	4,169	382	10	382		382	30
31	FRONT SIDEWALK	2011	8,850	738	10	738		738	31
32	DOOR OPERATORS	2011	11,541	962	10	962		962	32
33	DOORS	2011	2,119	159	10	159		159	33
34	TOTAL (lines 1 thru 33)		\$ 6,592,500	\$ 97,726		\$ 202,073	\$ 104,347	\$ 3,970,303	34

**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	\$ 264,929	\$ 29,349	\$ 29,349	\$		\$ 247,440	71
72	Current Year Purchases	44,961	6,063	6,063			6,063	72
73	Fully Depreciated Assets	1,543,000					1,543,000	73
74								74
75	TOTALS	\$ 1,852,890	\$ 35,412	\$ 35,412	\$		\$ 1,796,503	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	Facility Use	Trucks	various	\$ 78,760	\$ 13,964	\$ 13,964	\$	5	\$ 58,568	76
77	Resident Transportation	Vans	various	66,860	10,663	10,663		5	33,349	77
78	Resident Transportation	Auto-Fully Depreciated	various	21,103				5	21,103	78
79	Resident Transportation	Autos	various	36,827	4,003	4,003		5	22,346	79
80	TOTALS			\$ 203,550	\$ 28,630	\$ 28,630	\$		\$ 135,366	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)	\$ 8,648,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 161,768	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 266,115	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 104,347	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,902,172	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FRANCISCAN BROTHERS OF THE HOLY CROSS
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: \$
- Description:
- (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 1975

Ending 2012

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

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		375		375
3	Classroom Wages (a)		5,921		5,921
4	Clinical Wages (b)		11,842		11,842
5	In-House Trainer Wages (c)		5,990		5,990
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 24,128	\$	\$ 24,128
10	SUM OF line 9, col. 1 and 2 (e)	\$	24,128		

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	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

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

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,371,285	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	810,095		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,558		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,228,938	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,198,027		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,214,010		15
16	Equipment, at Historical Cost	2,071,861		16
17	Accumulated Depreciation (book methods)	(2,967,820)		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)	\$ 3,516,078	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,745,016	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 82,522	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,452		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		96,423		36
37		81,305		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 400,702	\$	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)	\$ 400,702	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,344,314	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,745,016	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,210,045	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,210,045	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	134,269	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)	\$ 134,269	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)	\$ 5,344,314	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	\$ 4,247,368	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,247,368	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	18,319	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	27,543	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,862	23
	D. Non-Operating Revenue		
24	Contributions	199,399	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 199,399	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	12,150	28
28a	Negative Interest	(31,170)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (19,020)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,473,609	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	824,883	31
32	Health Care	1,826,442	32
33	General Administration	1,025,527	33
	B. Capital Expense		
34	Ownership	431,768	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	230,720	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,339,340	40
41	Income before Income Taxes (line 30 minus line 40)**	134,269	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 134,269	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	1,887	2,145	\$ 57,780	\$ 26.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	16,028	16,712	312,730	18.71	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,924	2,054	23,554	11.47	8
9	Activity Director	2,270	2,446	32,390	13.24	9
10	Activity Assistants					10
11	Social Service Workers	1,920	2,080	39,062	18.78	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,120	37,885	17.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,764	19,079	169,306	8.87	15
16	Dishwashers					16
17	Maintenance Workers	3,747	4,099	59,276	14.46	17
18	Housekeepers	4,981	5,353	55,905	10.44	18
19	Laundry	3,478	3,995	48,875	12.23	19
20	Administrator	1,960	2,080	70,836	34.06	20
21	Assistant Administrator					21
22	Other Administrative	13,287	14,258	231,288	16.22	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	7,606	8,289	117,748	14.21	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,024	2,120	45,982	21.69	29
30	Habilitation Aides (DD Homes)	99,167	106,498	1,116,195	10.48	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,011	193,328	\$ 2,418,812 *	\$ 12.51	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	96	\$ 4,864	1,3	35
36	Medical Director				36
37	Medical Records Consultant	various	4,800	9,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	7	3,404	10,3	39
40	Physical Therapy Consultant	64	3,506	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	various	1,168	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	various	6,000	12,3	45
46	Other(specify)				46
47	Psychologist Consultant	various	14,160	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	167	\$ 37,902		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		
Ron Wampler	Administrator		\$70,836		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$70,836		
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		
Sikich	Audit		\$11,840		
INB/PNC	Trust		5,389		
Legal	Legal		183		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$17,412		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$127,747		
Unemployment Compensation Insurance			37,047		
FICA Taxes			174,080		
Employee Health Insurance			70,142		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
Life Insurance			5,393		
401K Contributions			81,305		
Continuing Education			4,007		
Staff Recognition			6,735		
Employee Physicals			6,650		
TOTAL (agree to Schedule V, line 22, col.8)			\$513,106		
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			4,816		
Health Care Worker Background Check (Indicate # of checks performed _____)			1,271		
Patient Background Checks					
Dues and Subscriptions			61		
Less: Public Relations Expense			()		
Non-allowable advertising			()		
Yellow page advertising			()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$6,148		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense					
Entertainment Expense			()		
TOTAL (agree to Sch. V, line 24, col. 8)			\$		

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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 230,720
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 27,543
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sikich
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.