

		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: <u>0047225</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																							
Facility Name: <u>Centralia Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/10</u> to <u>9/30/11</u> 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.																																																																																							
Address: <u>R.R. 1, Box 387 A</u> <u>Centralia</u> <u>62801</u>																																																																																									
Number City Zip Code																																																																																									
County: <u>Marion</u>																																																																																									
Telephone Number: <u>(618) 533-1200</u> Fax # <u>(618) 533-1257</u>																																																																																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Tina Calhoun</u></td></tr><tr><td>(Title) <u>Director of Operations</u></td></tr><tr><td>(Signed) <u>See Attached Independent Accountant's Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>McGladrey & Pullen, LLP</u></td></tr><tr><td><u>117 E. Main St., Suite 210</u></td></tr><tr><td>(Firm Name & Address) <u>P.O. Box 1070</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>06/29/05</u></td><td colspan="2"><u>Galesburg, IL 61401</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td></tr><tr><td colspan="2"><table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 (c) (3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table></td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2">ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td colspan="2">Name: <u>Ron Wilson</u></td><td colspan="2">201 S. Grand Avenue East</td></tr><tr><td colspan="2">Telephone Number: <u>(309) 343-1550</u></td><td colspan="2">Springfield, IL 62763-0001</td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Tina Calhoun</u>	(Title) <u>Director of Operations</u>	(Signed) <u>See Attached Independent Accountant's Report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>McGladrey & Pullen, LLP</u>	<u>117 E. Main St., Suite 210</u>	(Firm Name & Address) <u>P.O. Box 1070</u>	Date of Initial License for Current Owners: <u>06/29/05</u>		<u>Galesburg, IL 61401</u>		Type of Ownership:		(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>		<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 (c) (3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 (c) (3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____		MAIL TO: BUREAU OF HEALTH FINANCE		In the event there are further questions about this report, please contact:		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES		Name: <u>Ron Wilson</u>		201 S. Grand Avenue East		Telephone Number: <u>(309) 343-1550</u>		Springfield, IL 62763-0001		Email Address: _____		Phone # (217) 782-1630	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Centralia Manor # 0047225 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	302,216	25,238	9,624	337,078		337,078		337,078			1
2	Food Purchase		322,478		322,478		322,478		322,478			2
3	Housekeeping	121,675	39,899	817	162,391		162,391		162,391			3
4	Laundry	56,197	20,106		76,303		76,303		76,303			4
5	Heat and Other Utilities			162,209	162,209		162,209	180	162,389			5
6	Maintenance	38,124	18,041	104,171	160,336		160,336		160,336			6
7	Other (specify):*											7
8	TOTAL General Services	518,212	425,762	276,821	1,220,795		1,220,795	180	1,220,975			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,766,565	510,505	5,350	2,282,420		2,282,420		2,282,420			10
10a	Therapy			891,449	891,449		891,449		891,449			10a
11	Activities	95,364	2,538	85	97,987		97,987		97,987			11
12	Social Services	17,152			17,152		17,152		17,152			12
13	CNA Training											13
14	Program Transportation					3,607	3,607		3,607			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,879,081	513,043	908,884	3,301,008	3,607	3,304,615		3,304,615			16
	C. General Administration											
17	Administrative	135,864			135,864		135,864		135,864			17
18	Directors Fees							3,381	3,381			18
19	Professional Services			340,430	340,430		340,430	2,526	342,956			19
20	Dues, Fees, Subscriptions & Promotions			44,315	44,315		44,315	(32,783)	11,532			20
21	Clerical & General Office Expenses	65,101	33,955	52,385	151,441		151,441	(13,071)	138,370			21
22	Employee Benefits & Payroll Taxes			486,285	486,285		486,285		486,285			22
23	Inservice Training & Education			3,884	3,884		3,884		3,884			23
24	Travel and Seminar			3,145	3,145		3,145		3,145			24
25	Other Admin. Staff Transportation			7,213	7,213	(3,607)	3,606		3,606			25
26	Insurance-Prop.Liab.Malpractice			51,052	51,052		51,052	51,389	102,441			26
27	Other (specify):* See Att Sch V	42,035		(75,642)	(33,607)		(33,607)	33,607				27
28	TOTAL General Administration	243,000	33,955	913,067	1,190,022	(3,607)	1,186,415	45,049	1,231,464			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,640,293	972,760	2,098,772	5,711,825		5,711,825	45,229	5,757,054			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			97,433	97,433		97,433	265,416	362,849			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							408,840	408,840			32
33	Real Estate Taxes							346,204	346,204			33
34	Rent-Facility & Grounds			968,753	968,753		968,753	(968,753)				34
35	Rent-Equipment & Vehicles			3,383	3,383		3,383		3,383			35
36	Other (specify):* See Att Sch IV							10,450	10,450			36
37	TOTAL Ownership			1,069,569	1,069,569		1,069,569	62,157	1,131,726			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			60,927	60,927		60,927		60,927			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,983	5,983		5,983		5,983			41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* Outpatient Care			919	919		919		919			43
44	TOTAL Special Cost Centers			133,529	133,529		133,529		133,529			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,640,293	972,760	3,301,870	6,914,923		6,914,923	107,386	7,022,309			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		V-30		9
10	Interest and Other Investment Income	(5,516)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,080)	V-21		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	77,849	V-27		24
25	Fund Raising, Advertising and Promotional	(33,018)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(44,686)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (18,451)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	119,062		34
35	Other- Attach Schedule See Att Sch III	6,775		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 125,837		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 107,386		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

Centralia Manor

ID# 0047225

Report Period Beginning: 10/1/10

Ending: 9/30/11

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
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36				36
37				37
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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 A

9/30/11

[illegible]

Summary B

9/30/11

[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
None	N/A	Unlimited Development, Inc. (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

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	\$ 968,753	Centralia East McCord, LLC	N/A	\$ 1,087,815	\$ 119,062	1
2	V								2
3	V				See Att Schedule IV and Independent Accountant's Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 968,753			\$ 1,087,815	\$ * 119,062	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 3,381	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,381		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

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	Cambridge Realty Capital						\$					\$	1
2	LTD. Of Illinois		X	Facility purchase	\$39,235.40	6/1/11	8,626,000	8,607,880	7/1/2046	4.2000	414,356		2
3													3
4													4
5													5
	Working Capital												
6	Miscellaneous		X										6
7	Less Interest Income		X								(5,516)		7
8													8
9	TOTAL Facility Related				\$39,235.40		\$ 8,626,000	\$ 8,607,880			\$ 408,840		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$ 8,626,000	\$ 8,607,880			\$ 408,840		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,453 Line # 26

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

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

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

B. Real Estate Taxes

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.		\$	140,584	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.)				\$	276,893	2
3. Under or (over) accrual (line 2 minus line 1).				\$	136,309	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	207,395	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.)				\$	2,500	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.				\$	346,204	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006	130,257	8			
	2007	179,120	9			
	2008	184,316	10			
	2009	182,643	11			
	2010	276,892	12			
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.						
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.						
Taxes paid during year represents the entire 2010 bill.						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME Centralia Manor COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0047225

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

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.

B. Real Estate Tax Cost Allocations

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

YES	X	NO
-----	---	----

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

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: 43,758

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	6.4 Acres	2005	\$ 275,000	1
2					2
3	TOTALS	#VALUE!		\$ 275,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	120		2005		\$ 9,142,000	\$ 228,550	40	\$ 228,550	\$	\$ 1,428,438
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalks		2005		11,858	788	15	788		4,875
10	Parking Lot Lighting		2006		7,450	495	15	495		2,566
11	Roof		2007		5,555	554	10	554		2,268
12	Roof replacement		2008		60,650	6,065	10	6,065		21,228
13	Electric sign/13' Double Face Lighted		2008		43,127	4,311	10	4,311		13,657
14	Shower Room/VCT Restrooms - Servicing Area/Paint		2008		58,446	5,844	10	5,844		18,021
15	New Roof		2008		40,000	4,000	10	4,000		13,000
16	New Roof		2008		20,650	2,065	10	2,065		7,228
17	New Sign		2008		3,969	397	10	397		1,191
18	Carpet		2008		14,656	1,466	10	1,466		4,153
19	Physical Therapy Addition (Contracted Total)		2008		199,931	7,998	25	7,998		23,992
20	Air Conditioner		2009		4,685	468	10	468		1,132
21	Water Heater		2009		4,884	488	10	488		1,017
22	Dining Room Remodel (Contracted Total)		2009		214,154	18,226	12	18,226		36,452
23	Water Heater		2010		9,625	962	10	962		1,604
24	Show Rooms/Activity Room Cabinets/Armour/Painting/Flooring/Cascade		2010		162,466	13,539	12	13,539		21,437
25	Window Valances		2010		8,959	1,791	5	1,791		2,538
26	Windows		2010		17,416	1,161	15	1,161		1,451
27	Hot Water Heater		2011		7,500	313	10	313		313
28	Sprinklers		2011		17,727	59	25	59		59
29										
30										
31										
32										
33										
34										
35										
36										

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

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

****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	\$585,971	\$62,571	\$62,571		3-15 yrs	\$289,012	71
72	Current Year Purchases	13,570	738	738		10-12 yrs	738	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$599,541	\$63,309	\$63,309			\$289,750	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 Care	2003 Chevy G3500	2005	\$29,700				4 yrs	\$29,700	76
77										77
78										78
79										79
80	TOTALS			\$29,700					\$29,700	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)	\$10,959,949	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$362,849	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$362,849	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)	\$1,926,070	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	2006 Toyota Corolla - 2006	\$14,900		\$14,900	86
87					87
88					88
89					89
90					90
91	TOTALS	\$14,900		\$14,900	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:Centralia East McCord, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

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

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

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

15. Is Movable equipment rental included in building rental?☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 3,383Description: See Attached Schedule XII
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$ N/A
13.	/2013	\$ N/A
14.	/2014	\$ N/A

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$24,897	\$124,188	1
2	Cash-Patient Deposits	8,888	8,888	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance9,143)	800,623	800,623	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,643	140,039	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	4,060,190	4,099,044	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$4,992,241	\$5,172,782	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		275,000	13
14	Buildings, at Historical Cost		9,202,650	14
15	Leasehold Improvements, at Historical Cost	853,058	853,058	15
16	Equipment, at Historical Cost	336,141	644,141	16
17	Accumulated Depreciation (book methods)	(298,803)	(1,940,970)	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): See Att Sch VII		810,227	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$890,396	\$9,844,106	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$5,882,637	\$15,016,888	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$274,949	\$155,771	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,888	8,888	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	564,557	564,557	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,149	3,149	31
32	Accrued Real Estate Taxes(Sch.IX-B)		207,395	32
33	Accrued Interest Payable		30,128	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		1,337,731	36
37	Current portion of long term payable		111,423	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$851,543	\$2,419,042	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,496,457	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	43,390	43,390	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$43,390	\$8,539,847	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$894,933	\$10,958,889	46
47	TOTAL EQUITY(page 18, line 24)	\$4,987,704	\$4,057,999	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$5,882,637	\$15,016,888	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,676,029	1
2	Restatements (describe):		2
3	See Attached Schedule X	(11,755)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,664,274	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,323,430	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)	\$ 1,323,430	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)	\$ 4,987,704	24

*

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 7,902,141	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,902,141	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	314,449	6
7	Oxygen	5,280	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 319,729	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	8,331	12
13	Barber and Beauty Care	2,643	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	(74)	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,900	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***	5,516	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,566	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schedule XI	17	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,238,353	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,220,795	31
32	Health Care	3,301,008	32
33	General Administration	1,190,022	33
	B. Capital Expense		
34	Ownership	1,069,569	34
	C. Ancillary Expense		
35	Special Cost Centers	67,829	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,914,923	40
41	Income before Income Taxes (line 30 minus line 40)**	1,323,430	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,323,430	43

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

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

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

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

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	1,645	1,769	\$ 56,618	\$ 32.01	1
2	Assistant Director of Nursing	2,141	2,302	55,251	24.00	2
3	Registered Nurses	9,984	10,736	229,748	21.40	3
4	Licensed Practical Nurses	23,212	24,960	417,575	16.73	4
5	CNAs & Orderlies	87,093	93,649	903,711	9.65	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	8,491	9,131	95,364	10.44	10
11	Social Service Workers	1,276	1,372	17,152	12.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,357	31,567	302,216	9.57	15
16	Dishwashers					16
17	Maintenance Workers	2,854	3,069	38,124	12.42	17
18	Housekeepers	12,573	13,519	121,675	9.00	18
19	Laundry	6,149	6,611	56,197	8.50	19
20	Administrator	1,934	2,080	98,515	47.36	20
21	Assistant Administrator	1,930	2,075	37,349	18.00	21
22	Other Administrative	3,042	3,271	42,035	12.85	22
23	Office Manager					23
24	Clerical	5,260	5,655	65,101	11.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,951	2,098	34,295	16.35	31
32	Other Health Care(specify)	3,753	4,035	69,367	17.19	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,645	217,899	\$ 2,640,293 *	\$ 12.12	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		\$ 9,624	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant		800	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,550	10-3	39
40	Physical Therapy Consultant		406,888	10a-3	40
41	Occupational Therapy Consultant		354,798	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		129,763	10a-3	43
44	Activity Consultant			11-3	44
45	Social Service Consultant			12-3	45
46	Other(specify)		0	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 918,423		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Kathy Berck	Administrator	None	\$ 98,515
Carole Brink	Asst Admin	None	37,349
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 135,864
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
RFMS, Inc.	Administrative Services		\$ 171,600
McGladrey & Pullen, LLP	Accounting Services		8,540
RSM McGladrey	Accounting Services		6,120
LTC Support Services, LLC	Support Services		144,000
American Healthcare Manag.	Healthcare Services		3,053
Crain, Miller, & Wernsman	Legal Services		1,352
Polsinelli Shughart PC	Legal Services		5,765
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 340,430
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 127,504
Unemployment Compensation Insurance			29,958
FICA Taxes			195,216
Employee Health Insurance			113,117
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)* 401 (k)			14,552
Other Employee Benefits			5,938
TOTAL (agree to Schedule V, line 22, col.8)			\$ 486,285
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			1,207
Health Care Worker Background Check (Indicate # of checks performed)	104		2,924
Patient Background Checks	0		0
Advertising - Promotion			33,018
Subscriptions			241
IHCA Dues			4,168
Other Licenses & Fees			2,757
Indirect Costs - See Att Sch III			235
Less: Public Relations Expense		(	)
Non-allowable advertising			(33,018)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 11,532
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)			0
Seminar Expense			3,145
Less: non-allowable out-of-state travel			0
Indirect costs - See Att Sch III			0
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 3,145

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 11 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,090 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
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? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' COMPILATION REPORT