

		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: <u>0007880</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																									
Facility Name: <u>Country Health</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/11</u> to <u>12/31/11</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>RR1 Box 14</u> <u>Gifford</u> <u>61847</u>																																																																																											
Number City Zip Code																																																																																											
County: <u>Champaign</u>																																																																																											
Telephone Number: <u>217-568-7362</u> Fax # ()																																																																																											
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Chris Kasper</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Craig Ater</u> <u>Exec VP & CFO</u></td></tr><tr><td>(Firm Name & Address) <u>Heritage Operations Group, LLC</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>1970</u></td><td colspan="2">(Date) _____</td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">(Date) _____</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 _____</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"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2">Name: <u>Craig Ater</u></td><td colspan="2">ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td colspan="2">Telephone Number: (<u>309</u>) <u>823-7135</u></td><td colspan="2">201 S. Grand Avenue East</td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2">Springfield, IL 62763-0001</td></tr><tr><td colspan="2"></td><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Chris Kasper</u>	Paid Preparer	(Title) _____	(Signed) _____	(Print Name and Title) <u>Craig Ater</u> <u>Exec VP & CFO</u>	(Firm Name & Address) <u>Heritage Operations Group, LLC</u>	Date of Initial License for Current Owners: <u>1970</u>		(Date) _____		Type of Ownership:		(Date) _____		<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 _____</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 _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____				In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE		Name: <u>Craig Ater</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES		Telephone Number: (<u>309</u>) <u>823-7135</u>		201 S. Grand Avenue East		Email Address: _____		Springfield, IL 62763-0001				Phone # (217) 782-1630	
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Facility Name & ID Number Country Health

0007880 Report Period Beginning: 1/01/11 Ending: 12/31/11

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	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	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	8,552	9,022	2,603	20,177	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,552	9,022	2,603	20,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.11%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) none

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO x

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

I. On what date did you start providing long term care at this location? Date started 1970

J. Was the facility purchased or leased after January 1, 1978? YES NO x

K. Was the facility certified for Medicare during the reporting year? YES x NO If YES, enter number of beds certified and days of care provided 2,603

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL x MODIFIED CASH* CASH*

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

Tax Year: Fiscal Year:

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 1/01/11 Ending: 12/31/11

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	204,322	10,566		214,888		214,888		214,888			1
2	Food Purchase		134,552		134,552		134,552		134,552			2
3	Housekeeping	84,103	12,725		96,828		96,828		96,828			3
4	Laundry	53,951	9,007		62,958		62,958		62,958			4
5	Heat and Other Utilities			158,306	158,306		158,306		158,306			5
6	Maintenance	49,071	56,784	46,542	152,397		152,397		152,397			6
7	Other (specify):*											7
8	TOTAL General Services	391,447	223,634	204,848	819,929		819,929		819,929			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,220,707	78,657	7,348	1,306,712		1,306,712		1,306,712			10
10a	Therapy		151,598	380,446	532,044	(181,739)	350,305		350,305			10a
11	Activities	63,570	3,199		66,769		66,769		66,769			11
12	Social Services	31,943	65	3,680	35,688		35,688		35,688			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,316,220	233,519	404,674	1,954,413	(181,739)	1,772,674		1,772,674			16
	C. General Administration											
17	Administrative	87,347			87,347		87,347		87,347			17
18	Directors Fees											18
19	Professional Services			149,228	149,228		149,228	(4,878)	144,350			19
20	Dues, Fees, Subscriptions & Promotions			86,538	86,538	(48,728)	37,810	(17,147)	20,663			20
21	Clerical & General Office Expenses	154,669	13,576	4,767	173,012		173,012		173,012			21
22	Employee Benefits & Payroll Taxes			407,982	407,982		407,982		407,982			22
23	Inservice Training & Education			1,396	1,396		1,396		1,396			23
24	Travel and Seminar			5,828	5,828		5,828	(3,829)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			140,589	140,589		140,589		140,589			26
27	Other (specify):*											27
28	TOTAL General Administration	242,016	13,576	796,328	1,051,920	(48,728)	1,003,192	(25,854)	977,338			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,949,683	470,729	1,405,850	3,826,262	(230,467)	3,595,795	(25,854)	3,569,941			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			96,345	96,345		96,345		96,345			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,966	4,966		4,966		4,966			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,981	18,981		18,981		18,981			35
36	Other (specify):*											36
37	TOTAL Ownership			120,292	120,292		120,292		120,292			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					181,739	181,739		181,739			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,728	48,728		48,728			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					230,467	230,467		230,467			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,949,683	470,729	1,526,142	3,946,554		3,946,554	(25,854)	3,920,700			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		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees	(219)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,829)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,878)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(16,928)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,854)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (25,854)		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

Country Health

ID#0007880

Report Period Beginning:1/01/11

Ending:12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(219)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,878)	19	22
23				23
24		0	27	24
25		(16,928)	20	25
26				26
27				27
28				28
29			33	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	(22,025)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[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						

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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11								11
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25								25
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28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	attached								\$		1
2											2
3									0	line 18	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 1/01/11 Ending: 12/31/11

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	United Community		x	Construction/Remodel			\$	7,385,395			\$	1	
2												2	
3	Eastern Illini Co-op		x	Construction/Remodel				1,008,326				3	
4												4	
5												5	
	Working Capital												
6			xx	Working Capital							4,966	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	8,393,721			\$	4,966	9
	B. Non-Facility Related*												
10	Interest Income											10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	8,393,721			\$	4,966	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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Country Health</u>	COUNTY	<u>Champaign</u>
---------------	-----------------------	--------	------------------

FACILITY IDPH LICENSE NUMBER 0007880

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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.	nursing home	\$	\$
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:

34,102

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:

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				\$ 27,031	1
2					2
3	TOTALS			\$ 27,031	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	89				\$ 744,720	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1976 Improvements		1976		10,703					9
10	1977 Improvements		1979		15,361					10
11	1978 Improvements		1977		25,766					11
12	1979 Improvements		1978		6,618					12
13	1980 Improvements		1980		30,846					13
14	1981 Improvements		1981		18,567					14
15	1982 Improvements		1982		4,662					15
16	1983 Improvements		1983		28,833					16
17	1984 Improvements		1984		6,700					17
18	1985 Improvements		1985		33,953					18
19	1986 Improvements		1986		23,775					19
20	1987 Improvements		1987		40,603					20
21	1988 Improvements		1988		163,565					21
22	1989 Improvements		1989		50,581					22
23	1990 Improvements		1990		111,695					23
24	1991 Improvements		1991		36,516					24
25	1992 Improvements		1992		26,816					25
26	1993 Improvements		1993		21,383					26
27	1994 Improvements		1994		12,384					27
28	1995 Improvements		1995		5,450					28
29	NURSE CALL SYSTEM		1996		6,349					29
30	DINNING ROOM EXPANSION		1996		10,109					30
31	Dinning Room Remodel		1997		6,121					31
32										32
33										33
34	C/O Allocation									34
35	Book Depreciation					63,265		63,265		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 Country Health

0007880

Report Period Beginning:

1/01/11

Ending:

12/31/11

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dinning Room Remodel	1998	\$ 212,044	\$		\$	\$	\$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,891,513	\$ 63,265		\$ 63,265	\$	\$	70

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

1/01/11

Ending:

12/31/11

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		\$ 1,891,513	\$ 63,265		\$ 63,265	\$	\$	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19	Parking Lot Paving	2004	18,500						19
20	Door Locks	2004	5,992						20
21	Resident Room Remodel--Paint, flooring, drapes	2004	24,239						21
22	ansul system	2004	1,614						22
23	Board Room Remodel -- Paint	2004	1,550						23
24	Garage Door	2004	750						24
25	Door Alarm System	2004	10,861						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,017,721	\$ 63,265		\$ 63,265	\$	\$	34

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

1/01/11

Ending:

12/31/11

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		\$ 2,017,721	\$ 63,265		\$ 63,265	\$	\$	1
2									2
3	Resident Room Remodel-- Flooring, paint	2005	696						3
4	Door Alarm	2005	9,840						4
5	Board Room Remodel -- Paint	2005	741						5
6	Activity Room Remodel -- Paint, Flooring	2005	5,359						6
7	Employee Breakroom Remodel -- Paint	2005	1,182						7
8	Chiller	2005	46,799						8
9	Lobby Remodel -- Paint, Flooring	2005	23,981						9
10	Water valves	2005	24,320						10
11	Roof	2005	6,056						11
12	Nurse Call Station	2005	640						12
13	A/C Units	2005	5,127						13
14	Exterior Rehab	2005	1,172						14
15	Parking Lot Resurface	2005	1,449						15
16	CCTV Monitor and Camera	2005	2,407						16
17	Safety Control --Boiler	2005	1,180						17
18	Landscaping	2005	683						18
19	Dining Room Painting	2005	2,375						19
20	Flooring	2005	1,419						20
21									21
22	Dining Room Painting	2006	4,228						22
23	Landscaping	2006	1,411						23
24	Sewage Grinder	2006	18,519						24
25	Sidewalk	2006	1,997						25
26	Fire Door	2006	1,401						26
27	Resident Room Remodel-- Flooring, paint	2006	6,850						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,187,553	\$ 63,265		\$ 63,265	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 2,187,553	\$ 63,265		\$ 63,265	\$	\$	1
2								2
3 1/2 hp Auto Door Opener	2007	750						3
4 Water Heater	2007	6,517						4
5 Roof Repair	2007	851						5
6 Water Main	2007	1,462						6
7 Fire System	2007	1,662						7
8 Boiler	2007	1,044						8
9 Breakers	2007	1,393						9
10 Water Softener	2007	1,382						10
11								11
12 HVAC Units	2008	3,627						12
13 Mixing Valve	2008	8,834						13
14 Circulator Pump	2008	2,869						14
15								15
16 Water Heater	2009	2,860						16
17 Fire Door	2009	4,245						17
18								18
19 Water Main	2011	5,000						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 TOTAL (lines 1 thru 33)		\$ 2,230,049	\$ 63,265		\$ 63,265	\$	\$	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	\$919,142	\$33,080	\$33,080	\$		\$	71
72	Current Year Purchases	67,660						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$986,802	\$33,080	\$33,080	\$		\$	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		2008 van	2008	\$39,380	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$39,380	\$	\$	\$		\$	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)	\$3,283,262	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$96,345	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$96,345	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)	\$	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	New Wing & remodel	\$9,544,328	92
93			93
94			94
95		\$9,544,328	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 18,981 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 _____

Ending _____

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

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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	\$		\$	156,663	\$		156,663	1				
2	Licensed Speech and Language Development Therapist		hrs				24,127			24,127	2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist		hrs				169,359	156		169,515	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					151,442		151,442	9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
	Academic Education		hrs								11				
12	Other (specify):										12				
13	Other (specify):						30,297			30,297	13				
14	TOTAL			\$		\$	380,446	\$	151,598	\$	532,044	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	\$2,048,365	\$	1
2	Cash-Patient Deposits	7,377		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	725,959		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,198		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)	\$2,815,899	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	130,783		13
14	Buildings, at Historical Cost	2,153,510		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,014,124		16
17	Accumulated Depreciation (book methods)	(2,650,966)		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):	18,393		22
23	Other(specify): CIP	9,544,328		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$10,210,172	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$13,026,071	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$1,130,031	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,377		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	145,489		30
31	Accrued Taxes Payable (excluding real estate taxes)	148		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$1,283,045	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,393,721		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)	\$8,393,721	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$9,676,766	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$3,349,305	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$13,026,071	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$3,135,666	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$3,135,666	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	213,639	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)	\$213,639	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)	\$3,349,305	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	\$ 3,996,967	1
2	Discounts and Allowances for all Levels	(1,500,420)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,496,547	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,351,251	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,351,251	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	258,975	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,870	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 263,845	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,356	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,356	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		38,194	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,194	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,160,193	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	819,929	31
32	Health Care	1,954,413	32
33	General Administration	1,051,920	33
	B. Capital Expense		
34	Ownership	120,292	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,946,554	40
41	Income before Income Taxes (line 30 minus line 40)**	213,639	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 213,639	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	1,900	2,080	\$ 57,957	\$ 27.86	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,733	5,210	251,161	48.21	3
4	Licensed Practical Nurses	13,115	14,657	293,049	19.99	4
5	CNAs & Orderlies	36,408	39,478	583,363	14.78	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			35,177		8
9	Activity Director					9
10	Activity Assistants	3,640	4,030	63,570	15.77	10
11	Social Service Workers	1,676	1,826	31,943	17.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,150	17,882	204,322	11.43	15
16	Dishwashers					16
17	Maintenance Workers	3,277	3,466	49,071	14.16	17
18	Housekeepers	5,585	5,820	84,103	14.45	18
19	Laundry	6,440	8,148	53,951	6.62	19
20	Administrator	1,900	2,080	87,347	41.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,948	4,394	154,669	35.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,772	109,071	\$ 1,949,683 *	\$ 17.88	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		\$ 0		35
36	Medical Director		13,200		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,340		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,680		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,220		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		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				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Chris Kasper			\$ 87,347	Workers' Compensation Insurance		\$ 34,964	IDPH License Fee		\$ 0		
				Unemployment Compensation Insurance		(2,935)	Advertising: Employee Recruitment		6,832		
				FICA Taxes		149,151	Health Care Worker Background Check				
				Employee Health Insurance		215,808	(Indicate # of checks performed _____)		1,955		
				Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		0			7,250		
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		10,994	Dues & Subscriptions		7,134		
(List each licensed administrator separately.)			\$ 87,347	Central Office Allocation			License & Fees		4,961		
B. Administrative - Other							Central Office Allocation				
Description			Amount				Less: Public Relations Expense		(7,250)		
			\$				Non-allowable advertising		(219)		
							Yellow page advertising	(			
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 407,982	TOTAL (agree to Sch. V, line 20, col. 8)	\$	20,663		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Heritage Operations Group			\$ 136,200			\$	Out-of-State Travel	\$			
Principal Financial	audit		8,150								
			0								
			0				In-State Travel				
									3,997		
									78		
							Seminar Expense		1,753		
							Central Office		(3,829)		
Legal adj to Zero			4,878				Entertainment Expense	(			
							(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL		1,999		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 149,228								

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

no

(2) Are there any dues to nursing home associations included on the cost report?

yes

If YES, give association name and amount.

Illinois Health Care Association

(3) Did the nursing home make political contributions or payments to a political action organization?

yes

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?

(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 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$

5,000

 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. \$

48,728

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?

yes

 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$

0

 Has any meal income been offset against related costs?

yes

 Indicate the amount. \$

5,717

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

 If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

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?

yes

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

no

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

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

yes

Firm Name:

Sulaski & Webb

(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.