

		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>0020719</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																		
Facility Name: <u>Finnie Good Shepard Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2010</u> to <u>3/31/2011</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>400 South Maincross Street</u> <u>Galatia</u> <u>62935</u>																																																																																				
Number City Zip Code																																																																																				
County: <u>Saline</u>																																																																																				
Telephone Number: <u>618-268-4631</u> Fax # <u>618-268-4636</u>																																																																																				
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Barbara A. Finnie</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Vice President / Secretary</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>James C. Henson CPA</u> <u>President</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>James Henson, P.C.</u> <u>P.O. Box 280, Ridgway IL 62979</u></td><td></td></tr><tr><td colspan="2"></td><td>(Telephone) <u>618-272-3931</u> Fax # <u>618-272-7105</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>4/1/1985</u></td><td colspan="2" rowspan="5"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td></tr><tr><td colspan="2">Type of Ownership:</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>☐</td><td></td><td>☒</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td></td></tr></table></td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>James C. Henson</u> Telephone Number: <u>618-272-3931</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Barbara A. Finnie</u>		Paid Preparer	(Title) <u>Vice President / Secretary</u>		(Signed) _____	(Date) _____	(Print Name and Title) <u>James C. Henson CPA</u> <u>President</u>		(Firm Name & Address) <u>James Henson, P.C.</u> <u>P.O. Box 280, Ridgway IL 62979</u>				(Telephone) <u>618-272-3931</u> Fax # <u>618-272-7105</u>	Date of Initial License for Current Owners: <u>4/1/1985</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		Type of Ownership:		<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>☐</td><td></td><td>☒</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐		☒	Corporation	☐	Other _____	☐		☐	"Sub-S" Corp.	☐		☐		☐	Limited Liability Co.	☐		☐		☐	Trust	☐		☐		☐	Other _____	☐		IRS Exemption Code _____		In the event there are further questions about this report, please contact:		Name: <u>James C. Henson</u> Telephone Number: <u>618-272-3931</u>		Email Address: _____	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Finnie Good Shepard Nursing Home

0020719 Report Period Beginning: 4/1/2010 Ending: 3/31/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>73</u>	Skilled (SNF)	<u>73</u>	<u>26,645</u>	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	<u>73</u>	TOTALS	<u>73</u>	<u>26,645</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,081</u>	<u>5,394</u>	<u>1,470</u>	<u>14,945</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,081</u>	<u>5,394</u>	<u>1,470</u>	<u>14,945</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.09%

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)

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES

☐

NO

☒

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

YES

☒

NO

☐

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

Date started

1/15/1951

J. Was the facility purchased or leased after January 1, 1978?

YES

☐

Date

NO

☒

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

73

and days of care provided

1,470

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 3/31

Fiscal Year: 3/31

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Finnie Good Shepard Nursing Home # 0020719 Report Period Beginning: 4/1/2010 Ending: 3/31/2011
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	100,211	4,493	5,970	110,674	35	110,709		110,709			1
2	Food Purchase		91,811		91,811	(500)	91,311	(713)	90,598			2
3	Housekeeping	97,111	8,048		105,159		105,159		105,159			3
4	Laundry	30,125	4,813		34,938		34,938		34,938			4
5	Heat and Other Utilities			50,925	50,925		50,925		50,925			5
6	Maintenance	65,089	21,549	29,436	116,074	(6,000)	110,074	(980)	109,094			6
7	Other (specify):*											7
8	TOTAL General Services	292,536	130,714	86,331	509,581	(6,465)	503,116	(1,693)	501,423			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	455,938	31,184	4,896	492,018		492,018		492,018			10
10a	Therapy											10a
11	Activities	17,988	4,848	2,923	25,759	300	26,059		26,059			11
12	Social Services			1,125	1,125		1,125		1,125			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	473,926	36,032	8,944	518,902	300	519,202		519,202			16
	C. General Administration											
17	Administrative	340,689	2,413		343,102	67	343,169		343,169			17
18	Directors Fees											18
19	Professional Services			17,170	17,170		17,170		17,170			19
20	Dues, Fees, Subscriptions & Promotions			7,289	7,289	(402)	6,887	(417)	6,470			20
21	Clerical & General Office Expenses	76,718	10,730	8,465	95,913		95,913		95,913			21
22	Employee Benefits & Payroll Taxes			111,581	111,581	500	112,081		112,081			22
23	Inservice Training & Education			663	663		663		663			23
24	Travel and Seminar			1,557	1,557		1,557		1,557			24
25	Other Admin. Staff Transportation			3,972	3,972	8,103	12,075	(8,479)	3,596			25
26	Insurance-Prop.Liab.Malpractice			56,968	56,968		56,968		56,968			26
27	Other (specify):* Tax Penalties			395	395		395	(395)				27
28	TOTAL General Administration	417,407	13,143	208,060	638,610	8,268	646,878	(9,291)	637,587			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,183,869	179,889	303,335	1,667,093	2,103	1,669,196	(10,984)	1,658,212			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			23,702	23,702	(8,103)	15,599		15,599			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			318	318		318	(318)				32
33	Real Estate Taxes			28,353	28,353		28,353		28,353			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					6,000	6,000		6,000			35
36	Other (specify):*											36
37	TOTAL Ownership			52,373	52,373	(2,103)	50,270	(318)	49,952			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,341	207,479	227,820		227,820		227,820			39
40	Barber and Beauty Shops			2,538	2,538		2,538		2,538			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,857	39,857		39,857		39,857			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		20,341	249,874	270,215		270,215		270,215			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,183,869	200,230	605,582	1,989,681		1,989,681	(11,302)	1,978,379			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	(208)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(505)	2		13
14	Non-Care Related Interest	(318)	32		14
15	Non-Care Related Owner's Transactions	(284)	6		15
16	Personal Expenses (Including Transportation)	(8,479)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(395)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(417)	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)	\$ (10,606)		\$	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))	\$ (10,606)		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		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning:

ID#0020719

Ending:

4/1/2010

3/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary B

3/31/2011

[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
Bobby J. Finnie	50	N/A		Rose Creek Farm	Elizabethtown IL	Cattle Farm
Barbara A. Finnie	50	N/A		Rose Creek Farm	Elizabethtown IL	Cattle Farm

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	2	Beef	\$ 2,877	Rose Creek Farm	100.00%	\$ 2,877		1
2	V	6	Emergency Generator Rent	6,000	Rose Creek Farm	100.00%	5,304	(696)	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			\$ 8,877			\$ 8,181	\$ * (696)	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

Facility Name & ID Number Finnie Good Shepard Nursing Home # 0020719 Report Period Beginning: 4/1/2010 Ending: 3/31/2011

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	Barbara A. Finnie	Administrator	Administrator	50.00	None	50	100.00	Wages	\$ 323,375	17	1
2	Rebecca Nyberg	Office Manager	Office		None	40	100.00	Wages	39,610	21	2
3	Lisa Rine	Asst. Administrator	Asst. Administrator		None	18	43.75	Wages	17,314	17	3
4	Stephanie Todrank	Dietary Manager	Dietary		None	19	46.44	Wages	17,558	1	4
5	Kyle Finnie	Maintenance	Maintenance		None	20	50.00	Wages	13,500	6	5
6	Heather Nyberg	Director of Nursing	Nursing		None	24	60.00	Wages	30,044	10	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 441,401		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Finnie Good Shepard Nursing Home # 0020719 Report Period Beginning: 4/1/2010 Ending: 3/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$		\$			\$	1						
2													2						
3													3						
4													4						
5													5						
	Working Capital																		
6													6						
7													7						
8													8						
9	TOTAL Facility Related							\$		\$			\$	9					
	B. Non-Facility Related*																		
10	Chysler Financial		X	Vehicle	\$138.97	9/8/2008		7,000		3,815	9/23/2013		6.9900		318	10			
11																11			
12																12			
13																13			
14	TOTAL Non-Facility Related					\$138.97		\$ 7,000		\$ 3,815			\$ 318	14					
15	TOTALS (line 9+line14)							\$ 7,000		\$ 3,815			\$ 318	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	34,031	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.)		\$	27,041	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(6,990)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	35,343	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.		\$	28,353	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	24,141	8	
		2007	24,567	9	
		2008	25,862	10	
		2009	27,041	11	
		2010	28,854	12	
2010 Payable 2011 \$28,274 + 2011 Payable 2012 \$7,069 = \$35,343					

		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 Finnie Good Shepard Nursing Home COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0020719

CONTACT PERSON REGARDING THIS REPORT James C. Henson

TELEPHONE 618-272-3931 FAX #: 618-272-7105

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.)

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:	16,311	B. General Construction Type:	Exterior	Brick	Frame	Concrete	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	-----------------	--------------------------	----------

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	130,680	1951	\$ 1,750	1
2					2
3	TOTALS	130,680		\$ 1,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Finnie Good Shepard Nursing Home

0020719

Report Period Beginning:

4/1/2010

Ending:

3/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	61		1975		\$ 398,241	\$	33	\$	\$	\$ 398,241	4
5	12		1980		132,755		31.67			132,755	5
6			1982		116,067		15			116,067	6
7											7
8											8
	Improvement Type**										
9	Parking Lot		1982		2,284					2,284	9
10	Driveway & Parking Lot		1982		21,918					21,918	10
11	Concrete		1984		1,965					1,965	11
12	Various Improvements		1990		117,343	3,725	31.5	3,725		77,762	12
13	Various Improvements		1992		95,654	3,037	31.5	3,037		55,294	13
14	Drapes, TV Antenna		1993		4,974	158	31.5	158		2,823	14
15	Drapes		1996		3,053					3,053	15
16	A/C & Heating Unit		1997		4,500	115	39	115		1,579	16
17	Room Air Returns		2008		6,850	176	39	176		543	17
18	Roof		2010		13,500	338	20	338		338	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 919,104	\$ 7,549		\$ 7,549	\$	\$ 814,622	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$36,761	\$4,156	\$4,156	\$	7	\$26,664	71
72	Current Year Purchases	46,724	3,894	3,894		9	3,894	72
73	Fully Depreciated Assets	328,341					328,341	73
74								74
75	TOTALS	\$411,826	\$8,050	\$8,050	\$		\$358,899	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	Maintenance	1999 Dodge Van	1999	\$17,409	\$	\$	\$		\$17,409	76
77										77
78										78
79										79
80	TOTALS			\$17,409	\$	\$	\$		\$17,409	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)	\$1,350,089	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$15,599	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$15,599	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)	\$1,190,930	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	Chrysler Van 2004	\$28,165	\$1,875	\$26,060	86
87	Chrysler SUV 2008	31,138	6,228	16,089	87
88					88
89					89
90					90
91	TOTALS	\$59,303	\$8,103	\$42,149	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

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

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

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: \$ 6,000
- Description: Emergency Generator

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS		(d)	
		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)	\$			

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

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	39	hrs	\$	7,443	\$ 108,595	\$	7,443	\$ 108,595	1
2	Licensed Speech and Language Development Therapist	39	hrs		43	581		43	581	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39	hrs		6,819	94,648		6,819	94,648	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts		489		15,505	489	15,505	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Medical Testing	39			68	3,618		68	3,618	12
13	Other (specify): X-Rays	39			1	37		1	37	13
14	TOTAL			\$	14,863	\$ 207,479	\$ 15,505	14,863	\$ 222,984	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

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	\$ 227,437	\$	1
2	Cash-Patient Deposits	1,718		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	137,024		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,980		7
8	Accounts Receivable (owners or related parties)	350,737		8
9	Other(specify): <u>Accrued Interest & Advances</u>	1,633		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 720,529	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,750		13
14	Buildings, at Historical Cost	919,104		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	488,539		16
17	Accumulated Depreciation (book methods)	(1,212,579)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,814	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 917,343	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 27,764	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,946		30
31	Accrued Taxes Payable (excluding real estate taxes)	78,475		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,343		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DPA Overpayment</u>	20,400		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 171,928	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,815		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)	\$ 3,815	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 175,743	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 741,600	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 917,343	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 691,616	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 691,616	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,984	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)	\$ 49,984	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)	\$ 741,600	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	\$ 2,039,521	1
2	Discounts and Allowances for all Levels	(2,692)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,036,829	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,522	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,522	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Refunds & Adjustments</u>	314	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 314	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,039,665	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	509,581	31
32	Health Care	518,902	32
33	General Administration	638,610	33
	B. Capital Expense		
34	Ownership	52,373	34
	C. Ancillary Expense		
35	Special Cost Centers	230,358	35
36	Provider Participation Fee	39,857	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,989,681	40
41	Income before Income Taxes (line 30 minus line 40)**	49,984	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 49,984	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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	1,238	1,238	\$ 30,044	\$ 24.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,303	1,303	22,431	17.21	3
4	Licensed Practical Nurses	11,121	11,121	176,875	15.90	4
5	CNAs & Orderlies	26,540	26,540	226,589	8.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,775	1,775	17,988	10.13	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	966	966	17,558	18.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,706	9,706	82,653	8.52	15
16	Dishwashers					16
17	Maintenance Workers	4,052	4,052	65,089	16.06	17
18	Housekeepers	11,606	11,606	97,111	8.37	18
19	Laundry	3,593	3,593	30,125	8.38	19
20	Administrator	2,079	2,079	323,375	155.54	20
21	Assistant Administrator	910	910	17,314	19.03	21
22	Other Administrative					22
23	Office Manager	2,160	2,160	39,610	18.34	23
24	Clerical	2,367	2,367	37,107	15.68	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)	79,416	79,416	\$ 1,183,869 *	\$ 14.91	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	32	\$ 1,587	1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	1,125	11	44
45	Social Service Consultant	18	1,125	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	68	\$ 3,837		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-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.

Illinois Nursing Home Administrator's Assoc. \$100
- (3)

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

No

If YES, have these costs been properly adjusted out of the cost report?
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

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

7 yr.
- (6)

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

\$ 0

Line

N/A
- (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.

\$ 39,857

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.

\$ 500

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.

\$ 0

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

0

d. Have vehicle usage logs been maintained?

No

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

No

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.

\$ 0
- (17)

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

No

Firm Name:

N/A
- (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?

N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

Page 19 - Taxable Income Reconciliation:

Net Income Per Books	49,984
Depreciation Adjustment	<u>(11,634)</u>
	38,350
Non-Deductible Expenses	1,077
Net Operating Loss Carryforward	<u>(39,427)</u>
Taxable Income	<u>-</u>