

		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>0037713</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>GROUP HOME #5</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2010</u> to <u>06/30/2011</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>314 BACHMAN LANE</u> <u>GODFREY</u> <u>62035</u>																									
Number City Zip Code																									
County: <u>MADISON</u>																									
Telephone Number: <u>(618)466-0367</u> Fax # <u>(618)466-3652</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>MARTHA WARFORD</u></td></tr><tr><td>(Title) <u>EXECUTIVE DIRECTOR</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>KIMBERLY S, LOY, CPA</u> <u>PRINCIPAL</u></td></tr><tr><td>(Firm Name & Address) <u>SCHEFFEL & COMPANY, PC</u> <u>106 COUNTY ROAD, JERSEYVILLE, IL 62052</u></td></tr><tr><td>(Telephone) <u>(618)498-6841</u> Fax # <u>(618)498-6842</u></td></tr><tr><td>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></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MARTHA WARFORD</u>	(Title) <u>EXECUTIVE DIRECTOR</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>KIMBERLY S, LOY, CPA</u> <u>PRINCIPAL</u>	(Firm Name & Address) <u>SCHEFFEL & COMPANY, PC</u> <u>106 COUNTY ROAD, JERSEYVILLE, IL 62052</u>	(Telephone) <u>(618)498-6841</u> Fax # <u>(618)498-6842</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												
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Date of Initial License for Current Owners: <u>02/21/92</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>BRENDA MILLER</u> Telephone Number: <u>(618)466-0367</u>																									
Email Address: _____																									

Facility Name & ID Number GROUP HOME #5

0037713 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,247	0		5,247	13
14	TOTALS	5,247			5,247	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.85%

D. How many bed-hold days during this year were paid by the Department? 119 (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 ☒

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 02/21/92

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 02/21/92 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number GROUP HOME #5 # 0037713 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	45,096	691	1,253	47,040		47,040		47,040			1
2	Food Purchase		22,668		22,668		22,668		22,668			2
3	Housekeeping	17,336	3,153		20,489		20,489		20,489			3
4	Laundry											4
5	Heat and Other Utilities			11,869	11,869		11,869		11,869			5
6	Maintenance	21,753	1,187	7,228	30,168		30,168		30,168			6
7	Other (specify):* SECURITY	3,498	513	3,917	7,928		7,928		7,928			7
8	TOTAL General Services	87,683	28,212	24,267	140,162		140,162		140,162			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	197,375	1,412		198,787	(4,082)	194,705		194,705			10
10a	Therapy											10a
11	Activities	3,879	3,178	223	7,280		7,280		7,280			11
12	Social Services			2,137	2,137		2,137		2,137			12
13	CNA Training					4,082	4,082		4,082			13
14	Program Transportation	6,922			6,922		6,922		6,922			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	208,176	4,590	2,360	215,126		215,126		215,126			16
	C. General Administration											
17	Administrative	20,560		3,292	23,852		23,852		23,852			17
18	Directors Fees											18
19	Professional Services			6,098	6,098		6,098		6,098			19
20	Dues, Fees, Subscriptions & Promotions			3,750	3,750		3,750		3,750			20
21	Clerical & General Office Expenses	26,873	2,985	7,021	36,879		36,879		36,879			21
22	Employee Benefits & Payroll Taxes			82,055	82,055		82,055		82,055			22
23	Inservice Training & Education			262	262		262		262			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			12,737	12,737		12,737		12,737			26
27	Other (specify):*											27
28	TOTAL General Administration	47,433	2,985	115,215	165,633		165,633		165,633			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	343,292	35,787	141,842	520,921		520,921		520,921			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			20,040	20,040		20,040		20,040			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,816	49,816		49,816	(40,429)	9,387			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS			2,478	2,478		2,478		2,478			36
37	TOTAL Ownership			72,334	72,334		72,334	(40,429)	31,905			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,315	38,315		38,315		38,315			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,315	38,315		38,315		38,315			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	343,292	35,787	252,491	631,570		631,570	(40,429)	591,141			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(38,666)	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,763)	32-7		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,429)		\$	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))	\$ (40,429)		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

GROUP HOME #5

	ID#	0037713
Report Period Beginning:		07/01/2010
Ending:		06/30/2011

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
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/2011

[illegible]

Summary B

06/30/2011

[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
		BEVERLY FARM FOUNDATION	GODFREY			
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #6	GODFREY			

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

YES

X NO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Donald Perozzi	BOD						1
2	Kent Schuette	BOD						2
3	Barry Allswang	BOD						3
4	Hartley Carlton	BOD						4
5	Patricia Downey	BOD						5
6	Roger Queen	BOD						6
7	David Swain	BOD						7
8	Pamela Whisler	BOD						8
9	Keith Wright	BOD						9
10	George Walker	BOD						10
11	Leslie Landsman	BOD						11
12	Steve Schmidt	BOD						12
13	Terry Carlton	BOD						13
14	Keith Riddell	BOD						14
15	Jeff Rosignol	BOD						15
16	Nicholas Lynn	BOD						16
17	William McMahon	BOD						17
18	Alan Bradley	BOD						18
19	Glen Tiller	BOD						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 GROUP HOME #5 # 0037713 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	BOARD OF DIRECTORS	BOD	BOD	0.00	NONE	7	0.00		\$ 0	N/A	1
2	(SEE SCHEDULE VI)										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number GROUP HOME #5 # 0037713 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

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 BEVERLY FARM FOUNDATION &
Street Address GROUP HOMES #1, #2, #3, #4, #6
City / State / Zip Code GODFREY, IL 62035
Phone Number (618)466-0367
Fax Number (618)466-3652

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	\$ 3,538,126	\$	232	\$ 82,055	1
2	17-3	SCHOOL REIMBURSEMENT	WAGES	10,000	8	117,283		281	3,292	2
3	17-1	ADMINISTRATIVE SALARIES	HOURS	2,080	8	217,729	217,729	104	10,886	3
4	21-1	PERSONNEL/ACCOUNTING	HOURS	2,080	8	537,467	537,467	104	26,873	4
5	6-1	MAINTENANCE STAFF	HOURS	2,080	8	435,062	435,062	104	21,753	5
6	7-3	SECURITY/SAFETY	HOURS	2,080	8	78,331		104	3,917	6
7	7-1	SAFETY MANAGER	HOURS	2,080	8	69,959	69,959	104	3,498	7
8	7-2	SECURITY SUPPLIES	HOURS	2,080	8	10,262		104	513	8
9	6-2	MAINTENANCE SUPPLIES	HOURS	2,080	8	23,740		104	1,187	9
10	21-2	OSHA REQUIREMENTS	HOURS	2,080	8	48,496		104	2,425	10
11	21-3	CONSULTANTS	HOURS	2,080	8	120,226		104	6,011	11
12	11-3	ACTIVITIES OTHER	HOURS	2,080	8	4,450		104	223	12
13	26-3	INSURANCE	HOURS	2,080	8	254,745		104	12,737	13
14	19-3	LEGAL & ACCOUNTING	HOURS	2,080	8	198,964		64	6,098	14
15	14-1	TRANSPORTATION STAFF	HOURS	2,080	8	138,455	138,455	104	6,923	15
16	20-3	DUES/SUBS/ADVERTISING	HOURS	2,080	8	98,381		79	3,750	16
17	36-3	MORTGAGE INSURANCE	HOURS	2,080	8	49,555		104	2,478	17
18	32-3	INTEREST	HOURS	2,080	8	996,329		104	49,816	18
19	6-3	MAINTENANCE - OTHER	HOURS	2,080	8	97,670		104	4,884	19
20	11-1	ACTIVITIES STAFF	HOURS	2,080	8	77,560	77,560	104	3,878	20
21	11-2	ACTIVITIES SUPPLIES/OTH	HOURS	2,080	8	6,676		104	334	21
22	23-3	INSERVICE TRAINING	HOURS	2,080	8	5,241		104	262	22
23										23
24										24
25	TOTALS					\$ 7,124,707	\$ 1,476,232		\$ 253,793	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	GERSHMAN MORTGAGE		X	REFINANCE BONDS	\$3,048.00	07/01/10	\$ 497,765	\$ 486,876	08/01/31	0.0477	\$ 23,704	1	
2	LOSS ON BOND RETIREMENT		X								23,982	2	
3	AMORTIZATION OF DEBT COSTS		X								367	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,048.00		\$ 497,765	\$ 486,876			\$ 48,053	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 497,765	\$ 486,876			\$ 48,053	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 2,478 Line # 36-3

* 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 NAMEGROUP HOME #5COUNTYMADISON

FACILITY IDPH LICENSE NUMBER0037713

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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: 5,112

B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories ONE

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	10,000		\$ 5,000	1
2					2
3	TOTALS	10,000		\$ 5,000	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	16			1992	\$ 317,200	\$ 7,931	40	\$ 7,931	\$	\$ 152,016
5										
6										
7										
8										
	Improvement Type**									
9	BUS SHELTER			1996	188		5			188
10	ADMINISTRATION BUILDING			1997	55,609	1,391	40	1,391		20,165
11	HARDWARE			1998	546		10			546
12	SECURITY SYSTEM			1998	171		10			152
13	ELECTRICAL WORK			1999	1,211		10			1,211
14	NEW FLOORING			2000	1,625		5			1,625
15	DOOR			2000	1,170		5			1,170
16	SPRINKLER REPAIR			2000	5,476		5			5,476
17	FIRE ALARM PANEL			2002	76	8	10	8		65
18	DIGITAL THERMOMETER			2003	904	90	10	90		767
19	CABINETS & COUNTER TOPS			2003	5,806	581	10	581		4,936
20	TILE FLOORING - SWITCHBOARD AREA			2005	63	6	10	6		39
21	TRAINING BUILDING ALLOCATION			1998	1,481	96	15	96		1,256
22	BEDROOM FLOORING			2006	1,801	180	10	180		990
23	DOOR			2008	874	175	5	175		612
24	FLOORING			2009	793	159	5	159		397
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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)		\$ 394,994	\$ 10,617		\$ 10,617	\$	\$ 191,611	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 15,809	\$ 1,581	\$ 1,581	\$	5	\$ 1,581	71
72	Current Year Purchases	23,338	2,493	2,493		5-10	7,165	72
73	Fully Depreciated Assets	94,369	1,430	1,430		5-10	94,369	73
74								74
75	TOTALS	\$ 133,516	\$ 5,504	\$ 5,504	\$		\$ 103,115	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	SEE ATTACHED SCHEDULE			\$ 53,436	\$ 3,919	\$ 3,919	\$	5-10	\$ 43,142
77									
78									
79									
80	TOTALS			\$ 53,436	\$ 3,919	\$ 3,919	\$		\$ 43,142

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)			\$ 586,946
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 20,040
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 20,040
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 337,868

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$
- 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.

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

☒

☐

☐

72

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

88

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		75		75
3	Classroom Wages (a)		1,706		1,706
4	Clinical Wages (b)		2,086		2,086
5	In-House Trainer Wages (c)		215		215
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,082	\$	\$ 4,082
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,082		

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,404,411		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 1,404,411	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	394,994		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	186,952		16
17	Accumulated Depreciation (book methods)	(337,868)		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)	\$ 249,078	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,653,489	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	486,876		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)	\$ 486,876	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 486,876	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,166,613	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,653,489	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,149,515	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,149,515	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	17,098	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)	\$ 17,098	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)	\$ 1,166,613	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	\$ 648,668	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 648,668	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 648,668	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	140,162	31
32	Health Care	215,126	32
33	General Administration	165,633	33
	B. Capital Expense		
34	Ownership	72,334	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,315	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 631,570	40
41	Income before Income Taxes (line 30 minus line 40)**	17,098	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 17,098	43

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

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

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

****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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	13,282	14,566	166,877	11.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	310	349	3,878	11.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,630	3,846	45,096	11.73	15
16	Dishwashers					16
17	Maintenance Workers	1,769	1,962	21,753	11.09	17
18	Housekeepers	2,054	2,054	17,336	8.44	18
19	Laundry					19
20	Administrator	811	811	14,762	18.20	20
21	Assistant Administrator	104	104	3,289	31.63	21
22	Other Administrative	204	230	4,414	19.19	22
23	Office Manager					23
24	Clerical	2,234	2,453	24,968	10.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,907	2,115	29,498	13.95	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) ATTACHED	910	991	10,421	10.52	33
34	TOTAL (lines 1 - 33)	27,215	29,481	\$ 342,292 *	\$ 11.61	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	29	\$ 1,253	1-3	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				44
45	Social Service Consultant	85	2,137	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	114	\$ 3,390		49

C. CONTRACT NURSES

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

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

** See instructions.

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.

IL HEALTH CARE ASSN (\$293)

(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?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

YES

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

5-10 YRS

(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.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

XXX

NO

(10)

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

YES

NO

XXX

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.

\$ 38,315

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.

\$ 0

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?

YES

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?

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?

YES

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?

YES

Firm Name:

SCHEFFEL & COMPANY PC

(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.

GROUP HOME 5 - #0037713
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2011

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
TRANSPORTATION	706	787	\$ 6,923	8.80
SAFETY & SECURITY	204	204	3,498	17.15
	910	991	\$ 10,421	

GROUP HOME 5 (#0037713)
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.
JUNE 30, 2011

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
1995 CHEVY VAN #7	1,260	-	-	1,260
SUPPLY LUMINA	791	-	-	791
MAINTENANCE #2 TRUCK	707	-	-	707
CAR # 4 REPAIRS	208	-	-	208
LIFT ON VAN # 10	256	-	-	256
MAINT #3 AND SPREADER	596	-	-	596
MAINT #1 DUMP TRUCK	1,200	-	-	1,200
VAN #6 FORD E350	751	-	-	751
MAINT #7 -BUCKET TRUCK	450	-	-	450
TRANSPORT-IDOT VAN #12	2,694	-	-	2,694
TRANS MAINT #4-F150	330	-	-	330
FORD FOCUS-CAR #1	546	-	-	545
TRANSP-15 PASS. VAN #1	1,709	171	171	1,624
IDOT VAN #15	2,218	222	222	1,885
IDOT VAN #16	2,218	222	222	1,885
TRANS. MAINT #6 -TRUCK	299	-	-	299
MAINT. #8 F350 TRUCK	1,329	-	-	1,329
TRANS. CAR # 3	76	-	-	76
Trans- Car # 6	197	-	-	197
BUS RENNOVATIONS	259	-	-	259
TRANS-VAN # 13	1,245	-	-	1,245
WHEELCHAIR VAN #5	1,825	-	-	1,825
IDOT BUS-VAN #17	4,384	-	-	4,384
Supply Van Mats	11	-	-	11
E-350 Van #18-15 pass.	1,363	-	-	1,363
E-350 Van #19-15 pass.	1,369	-	-	1,369
2005 GMC-VAN # 3-15 pass.	1,415	-	-	1,415
2005 GMC-VAN # 11-15 pass.	1,417	-	-	1,417
Truck for Maintenance	257	26	26	257
Wheelchair Straps for Van #17	32	3	3	32
2006 Chrysler Van #21	833	83	83	833
2006 Chrysler Van #10	867	87	87	867
Wheelchair Van # 20	1,697	170	170	1,697
IDOT VAN-#8	1,835	183	183	1,009
Maintenance Truck w/Snow Plow	1,670	333	333	1,503
Vans-Wheelchair Strap	121	24	24	109
Security Car	660	132	132	594
Transportation Van	1,804	361	361	1,624
Transportation Van	1,433	286	286	1,003
IDOT Van	1,628	326	326	1,140
Maintenance - Truck	1,703	341	341	851
Shoulder Harnesses	86	17	17	26
14 Passenger Van	2,950	590	590	885
IDOT Van	2,887	157	157	157
2010 Chrysler	1,574	157	157	157
Maintenance Truck	276	28	28	28
	53,436	3,919	3,919	43,142