

		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>0033811</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Hope House</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/10</u> to <u>9/30/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>106 E. Second</u> <u>Arcola</u> <u>61910</u>																									
Number City Zip Code																									
County: <u>Douglas</u>																									
Telephone Number: <u>(217) 268-3732</u> Fax # <u>(217) 398-0944</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>Sherry Newton</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) <u>See attached compilation report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>James B. Eisenmenger, MS, CPA Member</u></td></tr><tr><td>(Firm Name & Address) <u>Martin, Hood, Frieze & Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u></td></tr><tr><td>(Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Sherry Newton</u>	(Title) <u>Chief Executive Officer</u>	(Signed) <u>See attached compilation report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>James B. Eisenmenger, MS, CPA Member</u>	(Firm Name & Address) <u>Martin, Hood, Frieze & Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u>	(Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>												
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	(Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>																								
Date of Initial License for Current Owners: <u>07/27/1988</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 _____</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 _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Sherry Newton</u> Telephone Number: <u>(217) 398-0754</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope House

0033811 Report Period Beginning: 10/01/10 Ending: 9/30/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		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	5,668			5,668	13
14	TOTALS	5,668			5,668	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.05%

D. How many bed-hold days during this year were paid by the Department? 138 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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

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

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

I. On what date did you start providing long term care at this location? Date started 07/27/1988

J. Was the facility purchased or leased after January 1, 1978? YES X Date 07/27/1988 NO

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

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 09/30/2011

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	33,136		1,401	34,537		34,537		34,537			1
2	Food Purchase		35,244		35,244		35,244		35,244			2
3	Housekeeping	26,381	5,108		31,489		31,489	58	31,547			3
4	Laundry	13,191	629		13,820		13,820		13,820			4
5	Heat and Other Utilities			18,226	18,226		18,226	1,867	20,093			5
6	Maintenance			21,424	21,424		21,424	10,325	31,749			6
7	Other (specify):*				0		0		0			7
8	TOTAL General Services	72,708	40,981	41,051	154,740	0	154,740	12,250	166,990			8
	B. Health Care and Programs											
9	Medical Director		2,366	3,000	5,366		5,366		5,366			9
10	Nursing and Medical Records	96,892	18	22,605	119,515		119,515	(4,043)	115,472			10
10a	Therapy				0		0		0			10a
11	Activities	13,191	8,253		21,444		21,444		21,444			11
12	Social Services				0		0		0			12
13	CNA Training	2,167			2,167		2,167		2,167			13
14	Program Transportation			2,146	2,146		2,146	1,186	3,332			14
15	Other (specify):*				0		0		0			15
16	TOTAL Health Care and Programs	112,250	10,637	27,751	150,638	0	150,638	(2,857)	147,781			16
	C. General Administration											
17	Administrative	42,707		101,492	144,199		144,199	(64,838)	79,361			17
18	Directors Fees				0		0	415	415			18
19	Professional Services			5,478	5,478		5,478	1,800	7,278			19
20	Dues, Fees, Subscriptions & Promotions			1,801	1,801		1,801	299	2,100			20
21	Clerical & General Office Expenses	13,191	556	3,849	17,596		17,596	12,487	30,083			21
22	Employee Benefits & Payroll Taxes			58,215	58,215		58,215	12,729	70,944			22
23	Inservice Training & Education			71	71		71	51	122			23
24	Travel and Seminar				0		0	565	565			24
25	Other Admin. Staff Transportation			920	920		920	3,870	4,790			25
26	Insurance-Prop.Liab.Malpractice			5,922	5,922		5,922	1,718	7,640			26
27	Other (specify):*				0		0		0			27
28	TOTAL General Administration	55,898	556	177,748	234,202	0	234,202	(30,904)	203,298			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	240,856	52,174	246,550	539,580	0	539,580	(21,511)	518,069			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			6,030	6,030		6,030	5,943	11,973			30
31	Amortization of Pre-Op. & Org.				0		0		0			31
32	Interest			42	42		42	(42)	0			32
33	Real Estate Taxes			6,397	6,397		6,397	2,271	8,668			33
34	Rent-Facility & Grounds			48,656	48,656		48,656		48,656			34
35	Rent-Equipment & Vehicles				0		0	396	396			35
36	Other (specify):*				0		0		0			36
37	TOTAL Ownership			61,125	61,125	0	61,125	8,568	69,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0		0			38
39	Ancillary Service Centers				0		0		0			39
40	Barber and Beauty Shops				0		0		0			40
41	Coffee and Gift Shops				0		0		0			41
42	Provider Participation Fee			39,532	39,532		39,532		39,532			42
43	Other (specify):* IL Repl. Tax			1,860	1,860		1,860	(1,860)	0			43
44	TOTAL Special Cost Centers	0	0	41,392	41,392	0	41,392	(1,860)	39,532			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	240,856	52,174	349,067	642,097	0	642,097	(14,803)	627,294			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,271)	32-3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,860)	43-3		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)	\$ (9,131)		\$ 0	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 Sch. VIII	(5,672)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,672)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (14,803)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Hope House

ID# 0033811

Report Period Beginning: 10/01/10

Ending: 9/30/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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25				25
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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

9/30/11

[illegible]

Summary B

9/30/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C		See Attached Schedule		Health Services Consul	Champaign, IL	Consulting
				Cobblestone Rehabilita	Champaign, IL	Therapy
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate
				Specialized Developme	Champaign, IL	Long-Term Care
				The Residential Develo	Champaign, IL	Long-Term Care

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		See Schedule VIII	\$			\$	\$	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.

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
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23								23
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25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 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	Alan Ryle	Chairman	Administrative	0.60	All related party wages are allocations from			Administrative	\$ 1,203	17-7	1
2	Lynn Ryle	Director	Administrative	0.00	HSC. See attached allocation spreadsheet			Administrative	1,203	17-7	2
3	Sherry Newton	CEO	Administrative	0.05	and explanation. These individuals receive			Administrative	10,788	17-7	3
4	Alan Ryle	Chairman	Director's Fees	0.60	no compensation from entities other			Director's Fees	208	18-7	4
5	Lynn Ryle	Director	Director's Fees	0.00	than HSC.			Director's Fees	207	18-7	5
6	Patti Hood			0.35							6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,609		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 Hope House # 0033811 Report Period Beginning: 10/01/10 Ending: 9/30/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Health Services Consultants, Inc.
Street Address P.O. Box 3037
City / State / Zip Code Champaign, IL 61826
Phone Number (217) 398-0754
Fax Number (217) 398-0944

	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	10	Nursing	Reverse actual amounts paid and accrued to HSC for services			\$	\$		(15,862)	1
2	17	Administrative	provided in order to allocate HSC'S actual expenses.						(101,492)	2
3										3
4	3	Housekeeping	Beds	370	207	1,346		16	58	4
5	5	Heat & Utilities	Beds	370	207	43,178		16	1,867	5
6	6	Maintenance	Beds	370	207	222,269	174,182	16	10,325	6
7	10	Nursing	Beds	370	207	228,545	228,545	16	11,819	7
8	14	Program Transportation	Beds	370	207	27,423		16	1,186	8
9	17	Administrative	Beds	370	207	877,639	848,001	16	36,654	9
10	18	Director's Fees	Beds	370	207	9,600		16	415	10
11	19	Professional Fees	Beds	370	207	41,626		16	1,800	11
12	20	Dues & Subscriptions	Beds	370	207	6,916		16	299	12
13	21	Clerical	Beds	370	207	288,764	224,647	16	12,487	13
14	22	P/R Taxes & Benefits	Beds	370	207	450,102		16	12,729	14
15	23	Inservice	Beds	370	207	1,187		16	51	15
16	24	Travel & Seminar	Beds	370	207	13,073		16	565	16
17	25	Administrative Transportation	Beds	370	207	89,483		16	3,870	17
18	26	Insurance	Beds	370	207	39,726		16	1,718	18
19	30	Depreciation	Beds	370	207	137,433		16	5,943	19
20	32	Interest	Beds	370	207	167,170		16	7,229	20
21	33	Real Estate Tax	Beds	370	207	52,510		16	2,271	21
22	35	Equipment Lease	Beds	370	207	9,152		16	396	22
23	N/A	Salaries & Wages	Beds	370	207	828,455	828,455	16	0	23
24										24
25	TOTALS					\$ 3,535,597	\$ 2,303,830		\$ (5,672)	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	Hyundai Motor Finance		X	Vehicle	\$293.10	01/13/11	\$ 17,586	\$ 15,241	01/27/16	0.0000	\$ 0	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Busey Bank		X	Working Capital	N/A	11/1/2010	N/A	0	11/1/2011	5.0000	42	6	
7	Schedule VIII Allocation		X								7,229	7	
8	Schedule VI Adjustment		X								(7,271)	8	
9	TOTAL Facility Related				\$293.10		\$ 17,586	\$ 15,241			\$ 0	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14	
15	TOTALS (line 9+line14)						\$ 17,586	\$ 15,241			\$ 0	15	

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.		\$	6,654	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.)				\$	6,410	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(244)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	6,641	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.				\$	6,397	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	9,801	8	FOR BHF USE ONLY	
		2007	6,692	9		
		2008	7,460	10		
		2009	6,468	11		
		20010	6,410	12		
Real esate tax accrual is based on estimated 2011 tax				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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Hope House</u>	COUNTY	<u>Douglas</u>
---------------	-------------------	--------	----------------

FACILITY IDPH LICENSE NUMBER 0033811

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	01-14-09-215-007	Facility	\$ 6,410.00	\$ 6,410.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 6,410.00	\$ 6,410.00

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: 4,600

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

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$ 0	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Air Conditioning Unit			1998	1,200	44	27	44		583
10	Patio Improvements			1998	1,127	42	27	42		546
11	Protective Wall Covering			2001	1,350	34	40	34		372
12	Water Heater			2005	619	23	27.5	23		146
13	Vinyl Tile Flooring			2004	2,424		5			2,424
14	Sprinkler System			2005	3,201	116	27.5	116		677
15	Water Service Piping			2006	1,600	107	15	107		535
16	Furnace			2007	750	107	7	107		366
17	Air Conditioning Unit			2007	3,430	125	27.5	125		382
18	Air Conditioning Unit			2007	3,430	125	27.5	125		382
19	Fire Panel and Annunciator			2009	1,614	323	5	323		673
20	Wood Flooring			2009	4,675	935	5	935		1,870
21	Tile Flooring			2009	613	123	5	123		246
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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		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)		\$ 26,033	\$ 2,103		\$ 2,103	\$ 0	\$ 9,201	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	\$ 7,873	\$ 1,255	\$ 1,255	\$ 0	5/7	\$ 5,745	71
72	Current Year Purchases	538	90	90	0	5	90	72
73	Fully Depreciated Assets	5,591			0	5/7	5,591	73
74					0			74
75	TOTALS	\$ 14,002	\$ 1,345	\$ 1,345	\$ 0		\$ 11,426	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2001 GMC Savana	2001	\$ 25,022	\$	\$	\$ 0	5	\$ 25,022	76
77	Patient Transportation	2010 Hyundai Elantra	2011	17,211	2,582	2,582	0	5	2,582	77
78							0			78
79							0			79
80	TOTALS			\$ 42,233	\$ 2,582	\$ 2,582	\$ 0		\$ 27,604	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)	\$ 82,268	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,030	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,030	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,231	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Milestone Midwest, Inc.
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.

XYES

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:	1988	15		\$48,656			3
4	Additions	1991	1					4
5								5
6								6
7	TOTAL		16		\$48,656			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

XNO

Terms: N/A*

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

15. Is Movable equipment rental included in building rental?

YES

XNO

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.		\$
13.		\$
14.		\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)		722		722
4	Clinical Wages (b)		1,445		1,445
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 2,167	\$ 0	\$ 2,167
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,167			

C. CONTRACTUAL INCOME

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

\$None

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,051)	120,472		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)	\$ 120,622	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	26,033		15
16	Equipment, at Historical Cost	56,235		16
17	Accumulated Depreciation (book methods)	(48,231)		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)	\$ 34,037	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 154,659	\$ 0	25

		1	2	
		Operating	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	3,542		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,641		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)	\$ 10,183	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,241		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)	\$ 15,241	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 25,424	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 129,235	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 154,659	\$ 0	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 169,229	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 169,229	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	147,819	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)	\$ 147,819	17
	B. Transfers (Itemize):		
18	Transfers (to) from Developmental Foundations, Inc.	(187,813)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (187,813)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 129,235	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	\$ 782,645	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 782,645	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)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,271	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,271	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 789,916	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	154,740	31
32	Health Care	150,638	32
33	General Administration	234,202	33
	B. Capital Expense		
34	Ownership	61,125	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,532	36
	D. Other Expenses (specify):		
37	Illinois Replacement Taxes	1,860	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 642,097	40
41	Income before Income Taxes (line 30 minus line 40)**	147,819	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 147,819	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. Tax Return is on a 12/31 fiscal year.

*** 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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	240	240	2,167	9.03	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,460	1,460	13,191	9.03	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,377	1,456	13,350	9.17	14
15	Cook Helpers/Assistants	2,190	2,190	19,786	9.03	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,920	2,920	26,381	9.03	18
19	Laundry	1,460	1,460	13,191	9.03	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,138	2,340	42,707	18.25	22
23	Office Manager					23
24	Clerical	1,460	1,460	13,191	9.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,425	1,560	28,471	18.25	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	6,026	7,573	68,421	9.03	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,696	22,659	\$ 240,856 *	\$ 10.63	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		\$ 1,401	1-3	35
36	Medical Director		3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		15,296	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		2,456	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		3,000	10-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychologist		150	10-3	47
48	Dentist		695	10-3	48
49	TOTAL (lines 35 - 48)		\$ 25,998		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.

STATE OF ILLINOIS

Facility Name & ID Number

Hope House

0033811

Report Period Beginning: 10/01/10

Page 21

Ending: 9/30/11

A. Administrative Salaries

Name

Function

Ownership

Amount

Mike C. Addams

Other/Admin

0

\$ 21,185

Sharlyn Linker

Other/Admin

0

21,426

Ella M. Walters

Other/Admin

0

96

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 42,707

B. Administrative - Other

Description

Amount

Management & Support Staff Fee

\$ 101,492

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 101,492

C. Professional Services

Vendor/Payee

Type

Amount

Martin, Hood, Friese & Associates

Accounting

\$ 3,295

Thomas, Mamer & Haughey

Legal

70

Various

Other Professional Services

2,113

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 5,478

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 8,300

Unemployment Compensation Insurance

3,106

FICA Taxes

18,425

Employee Health Insurance

16,910

Employee Meals

6,608

Illinois Municipal Retirement Fund (IMRF)*

Other

4,866

Schedule VIII Allocation

12,729

TOTAL (agree to Schedule V, line 22, col.8)

\$ 70,944

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

None

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,047

Advertising: Employee Recruitment

525

Health Care Worker Background Check

(Indicate # of checks performed 7)

229

Patient Background Checks

Schedule VIII Allocation

299

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 2,100

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Schedule VIII Allocation

565

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 565

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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. IARF - \$992

(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? N/A

(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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None 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 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. \$ 39,532
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? Yes
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? None

(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. \$ 6,608
Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No
If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Attached
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? None
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? 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? None

(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