

		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>0047324</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Manor Court of Princeton</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/2010</u> to <u>03/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>140 North Sixth Street</u> <u>Princeton</u> <u>61356</u>																																																	
Number City Zip Code																																																	
County: <u>Bureau</u>																																																	
Telephone Number: <u>(815) 875-6600</u> Fax # <u>(815) 875-6005</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>Darcee Fanning</u></td></tr><tr><td>(Title) <u>Regional Director</u></td></tr><tr><td>(Signed) <u>See Attached Independent Accountant's Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>McGladrey & Pullen, LLP</u></td></tr><tr><td><u>117 E Main Street, Suite 210</u></td></tr><tr><td>(Firm Name & Address) <u>P.O. Box 1070</u></td></tr><tr><td colspan="2" rowspan="4"></td><td><u>Galesburg, IL 61401</u></td></tr><tr><td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td></tr><tr><td colspan="2" rowspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr><tr><td></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Darcee Fanning</u>	(Title) <u>Regional Director</u>	(Signed) <u>See Attached Independent Accountant's Report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>McGladrey & Pullen, LLP</u>	<u>117 E Main Street, Suite 210</u>	(Firm Name & Address) <u>P.O. Box 1070</u>			<u>Galesburg, IL 61401</u>	(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</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>12/21/04</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 (c) 3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td>☐</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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		☐	Other _____	☐	_____																																												
In the event there are further questions about this report, please contact:																																																	
Name: <u>Ron Wilson</u>		Telephone Number: <u>(309) 343-1550</u>																																															
Email Address: _____																																																	

Facility Name & ID Number Manor Court of Princeton

0047324 Report Period Beginning: 04/01/2010 Ending: 03/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,740</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>22</u>	Sheltered Care (SC)	<u>22</u>	<u>8,030</u>	5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,589</u>	<u>6,442</u>	<u>5,547</u>	<u>24,578</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC	<u>1,114</u>	<u>6,293</u>		<u>7,407</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,703</u>	<u>12,735</u>	<u>5,547</u>	<u>31,985</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.42%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/3/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1/3/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 76 and days of care provided 5,302

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 03/31/2011 Fiscal Year: 03/31/2011

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

Facility Name & ID Number Manor Court of Princeton # 0047324 Report Period Beginning: 04/01/2010 Ending: 03/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	287,327	21,300	6,343	314,970		314,970	(68,072)	246,898			1
2	Food Purchase		358,051		358,051		358,051	(79,177)	278,874			2
3	Housekeeping	136,779	36,765		173,544		173,544	(23,873)	149,671			3
4	Laundry	46,267	15,341		61,608		61,608	(8,475)	53,133			4
5	Heat and Other Utilities			142,316	142,316		142,316	(30,756)	111,560			5
6	Maintenance	69,884	29,250	38,633	137,767		137,767	(18,784)	118,983			6
7	Other (specify):*											7
8	TOTAL General Services	540,257	460,707	187,292	1,188,256		1,188,256	(229,137)	959,119			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,950,240	283,787	6,455	2,240,482		2,240,482	(400,964)	1,839,518			10
10a	Therapy			669,366	669,366		669,366		669,366			10a
11	Activities	76,839	2,499		79,338		79,338	(344)	78,994			11
12	Social Services	22,072			22,072		22,072		22,072			12
13	CNA Training											13
14	Program Transportation			646	646	4,865	5,511		5,511			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,049,151	286,286	682,467	3,017,904	4,865	3,022,769	(401,308)	2,621,461			16
	C. General Administration											
17	Administrative	112,540			112,540		112,540	(15,481)	97,059			17
18	Directors Fees							2,825	2,825			18
19	Professional Services			256,931	256,931		256,931	(31,898)	225,033			19
20	Dues, Fees, Subscriptions & Promotions			96,108	96,108		96,108	(86,774)	9,334			20
21	Clerical & General Office Expenses	64,167	37,204	31,537	132,908		132,908	(17,095)	115,813			21
22	Employee Benefits & Payroll Taxes			482,643	482,643		482,643	(89,857)	392,786			22
23	Inservice Training & Education			2,334	2,334		2,334		2,334			23
24	Travel and Seminar			1,225	1,225		1,225		1,225			24
25	Other Admin. Staff Transportation			9,729	9,729	(4,865)	4,864	(905)	3,959			25
26	Insurance-Prop.Liab.Malpractice			76,971	76,971		76,971	(10,103)	66,868			26
27	Other (specify):* See Att Sch V	36,059		68,591	104,650		104,650	(104,650)				27
28	TOTAL General Administration	212,766	37,204	1,026,069	1,276,039	(4,865)	1,271,174	(353,938)	917,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,802,174	784,197	1,895,828	5,482,199		5,482,199	(984,383)	4,497,816			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			40,078	40,078		40,078	296,916	336,994			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							209,996	209,996			32
33	Real Estate Taxes			107,600	107,600		107,600	(23,672)	83,928			33
34	Rent-Facility & Grounds			821,627	821,627		821,627	(821,627)				34
35	Rent-Equipment & Vehicles			730	730		730		730			35
36	Other (specify):* Loan fee amort							5,013	5,013			36
37	TOTAL Ownership			970,035	970,035		970,035	(333,374)	636,661			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			4,958	4,958		4,958		4,958			41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			46,568	46,568		46,568		46,568			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,802,174	784,197	2,912,431	6,498,802		6,498,802	(1,317,757)	5,181,045			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	(204)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(1,006)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions		V-27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,817)	V-27		24
25	Fund Raising, Advertising and Promotional	(85,930)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(867,334)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,021,291)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(303,952)		34
35	Other- Attach Schedule See Att Sch III	7,486		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (296,466)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,317,757)		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

Manor Court of Princeton

ID#	0047324
Report Period Beginning:	04/01/2010
Ending:	03/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
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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

03/31/2011

[illegible]

Summary B

03/31/2011

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)		See Attached Schedule I		
		Residential Alternatives of Iowa				
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Concepts Plus, Inc. (FH is sole member)				
		See Attached Schedule I for specific homes				

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility rent	\$ 821,627	Hawthorne Inn of Princeton, LLC	N/A	\$ 517,675	\$ (303,952)	1
2	V								2
3	V				See Att Schedule XI				3
4	V								4
5	V				LTC Support Services, LLC				5
6	V				See Attached Independent Accountant's Report				6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 821,627			\$ 517,675	\$ * (303,952)	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Manor Court of Princeton # 0047324 Report Period Beginning: 04/01/2010 Ending: 03/31/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II								\$ 2,825	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,825		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 Manor Court of Princeton # 0047324 Report Period Beginning: 04/01/2010 Ending: 3/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Residential Alternatives of Illinois, Inc.
Street Address 285 S. Farnham
City / State / Zip Code Galesburg, IL 61401
Phone Number (309) 343-1550
Fax Number (309) 343-2857

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	See Attached Schedule II & III				\$	\$		\$ 7,486	1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$ 7,486	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	Midland States Bank		X	facility purchase	\$22,183.00	10/02/09	\$ 3,992,931	\$ 3,592,245	10/02/12	5.7500	\$ 211,002	1	
2				SNF portion								2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home office allocation adj	X		See Att Sch III								6	
7	Less Interest Income		X	from page 5, line 10							(1,006)	7	
8												8	
9	TOTAL Facility Related				\$22,183.00		\$ 3,992,931	\$ 3,592,245			\$ 209,996	9	
	B. Non-Facility Related*												
10	Midland States Bank		X	facility purchase	\$6,257.00	10/02/09	1,126,211	1,013,197	10/02/12	5.7500	59,514	10	
11				SLF portion								11	
12												12	
13												13	
14	TOTAL Non-Facility Related				\$6,257.00		\$ 1,126,211	\$ 1,013,197			\$ 59,514	14	
15	TOTALS (line 9+line14)						\$ 5,119,142	\$ 4,605,442			\$ 269,510	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	135,288	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.)		\$	106,053	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(29,235)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	136,835	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.		\$	107,600	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	98,180	8	
		2007	101,660	9	
		2008	104,473	10	
		2009	106,053	11	
		2010	108,896	12	
The facility is leased from a related for-profit entity. The lease agreement requires the lessee to pay the real estate taxes. Amount accrued includes 12 months of 2010 and 3 months of 2011. The real estate tax estimate is based on the 2010 tax bill. Real estate taxes paid during the year were for the 2009 bill. See Att Sch VI for portion of real estate taxes allocated to supportive living and Att Sch X for calculation of SNF allocation.				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.

FACILITY NAME	<u>Manor Court of Princeton</u>	COUNTY	<u>Bureau</u>
FACILITY IDPH LICENSE NUMBER	<u>0047324</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Ron Wilson</u>		
TELEPHONE	<u>(309) 343-1550</u>	FAX #:	<u>(309) 343-2857</u>

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.

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: 38,703

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility - SNF</u>		<u>2009</u>	<u>\$ 50,700</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 50,700</u>	<u>3</u>

Facility Name & ID Number Manor Court of Princeton

0047324

Report Period Beginning:

04/01/2010

Ending:

03/31/2011

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	98		2009		\$ 5,371,483	\$ 214,852	25	\$ 214,852	\$	\$ 284,493
5										
6										
7										
8										
	Improvement Type**									
9	Electric Signs			2005	4,098	411	10	411		2,459
10	Electrical Lighting - Landscaping, Fiberglass Insulation			2006	12,540	950	10-15 yrs	950		4,446
11	Sign			2007	2,600	260	10	260		932
12	New Roof			2008	144,175	14,417	10	14,417		40,850
13	Paved Parking Lot and Sidewalks			2009	174,778	11,652	15	11,652		15,536
14	AC Unit Kitchen			2010	5,429	317	10	317		317
15	Dry Valve for Sprinkler System			2011	7,258	181	10	181		181
16	Dining Room Wallpaper/Paint/Carpet/Desk/Countertops			2011	14,230	237	10	237		237
17	3x6 Single Face Lighted Sign			2010	2,620	240	10	240		240
18	Shower Remodels			2011	7,350	61	10	61		61
19	Office Partitions			2011	2,893	24	10	24		24
20	Physical Therapy Addition and Fixtures			2010	526,495	25,594	12	25,594		25,594
21										
22										
23										
24										
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		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)		\$ 6,275,949	\$ 269,196		\$ 269,196	\$	\$ 375,370	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	\$655,599	\$63,829	\$63,829		3-20 yrs	\$170,996	71
72	Current Year Purchases	89,442	3,969	3,969		5-12 yrs	3,969	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$745,041	\$67,798	\$67,798			\$174,965	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2005 Ford E350 Van	2005	\$46,919				4 yrs	\$46,919	76
77										77
78										78
79										79
80	TOTALS			\$46,919					\$46,919	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)	\$7,118,609	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$336,994	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$336,994	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$597,254	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	Truck - 2004	\$3,500		\$3,500	86
87	2003 GMC Van - 2005	29,800		29,800	87
88	2000 Ford F250 - 2006	8,425	1,404	8,425	88
89	See Att Sch XII	1,942,951	91,485	119,016	89
90	See Att Sch XIII	16,300	3,340	2,719	90
91	TOTALS	\$2,000,976	\$96,229	\$163,460	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$730
- Description: See Attached Schedule XIV
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 33,975	\$ 33,975	1
2	Cash-Patient Deposits	12,840	12,840	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	644,171	644,171	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,055	44,055	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 735,041	\$ 735,041	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		65,000	13
14	Buildings, at Historical Cost		7,561,510	14
15	Leasehold Improvements, at Historical Cost	203,193	463,331	15
16	Equipment, at Historical Cost	354,357	1,029,744	16
17	Accumulated Depreciation (book methods)	(250,016)	(760,738)	17
18	Deferred Charges		18,498	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(9,220)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in process</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 307,534	\$ 8,368,125	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,042,575	\$ 9,103,166	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 95,325	\$ 95,325	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,840	12,840	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	83,599	83,599	31
32	Accrued Real Estate Taxes(Sch.IX-B)	136,835	136,835	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision payable</u>	232,562	3,463,958	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 561,161	\$ 3,792,557	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,605,442	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Construction payable</u>			43
44	<u>Security Deposits</u>	89,263	89,263	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 89,263	\$ 4,694,705	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 650,424	\$ 8,487,262	46
47	TOTAL EQUITY(page 18, line 24)	\$ 392,151	\$ 615,904	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,042,575	\$ 9,103,166	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (148,579)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (148,579)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	540,730	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)	\$ 540,730	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)	\$ 392,151	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	\$ 6,977,367	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,977,367	3
	B. Ancillary Revenue		
4	Day Care	22,340	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	4,070	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 26,410	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	7,532	12
13	Barber and Beauty Care	8,635	13
14	Non-Patient Meals	204	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)	\$ 16,371	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,006	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,006	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Sch VII	18,378	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,378	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,039,532	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,188,256	31
32	Health Care	3,017,904	32
33	General Administration	1,276,039	33
	B. Capital Expense		
34	Ownership	970,035	34
	C. Ancillary Expense		
35	Special Cost Centers	4,958	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,498,802	40
41	Income before Income Taxes (line 30 minus line 40)**	540,730	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 540,730	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	1,797	1,932	\$ 49,251	\$ 25.49	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	12,680	13,634	308,135	22.60	3
4	Licensed Practical Nurses	13,415	14,425	275,376	19.09	4
5	CNAs & Orderlies	103,764	111,574	1,181,571	10.59	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	7,726	8,308	76,839	9.25	10
11	Social Service Workers	1,785	1,919	22,072	11.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,978	29,009	287,327	9.90	15
16	Dishwashers					16
17	Maintenance Workers	4,637	5,040	69,884	13.87	17
18	Housekeepers	13,051	14,033	136,779	9.75	18
19	Laundry	4,407	5,095	46,267	9.08	19
20	Administrator	1,934	2,080	82,199	39.52	20
21	Assistant Administrator	1,881	2,023	30,341	15.00	21
22	Other Administrative	2,180	2,345	36,059	15.38	22
23	Office Manager					23
24	Clerical	5,404	5,811	64,167	11.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,992	2,142	44,370	20.71	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,843	1,982	20,813	10.50	31
32	Other Health Care(specify)	3,193	3,433	70,724	20.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,667	224,785	\$ 2,802,174 *	\$ 12.47	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	***	\$ 6,343	1-3	35
36	Medical Director	***	6,000	9-3	36
37	Medical Records Consultant	***	1,840	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	4,615	10-3	39
40	Physical Therapy Consultant	***	313,254	10a-3	40
41	Occupational Therapy Consultant	***	248,897	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	96,345	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47					47
48	*** Monthly fee				48
49	TOTAL (lines 35 - 48)		\$ 677,294		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Kathleen Dilbeck	Administrator	None	\$82,199
Penny Lusietto	Asst. Admin	None	30,341
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$112,540
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
RFMS, Inc.	Administrative Services		\$144,000
LTC Support Services, LLC	Support Services		94,800
McGladrey & Pullen, LLP	Accounting Services		12,690
American Healthcare	Healthcare Services		5,166
Polsinelli Shughart PC	Legal Services		275
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$256,931
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$123,675
Unemployment Compensation Insurance			21,905
FICA Taxes			209,558
Employee Health Insurance			103,819
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)* 401(k)			17,571
Other Employee Benefits			6,115
Less Allocation for SLF portion			(89,857)
TOTAL (agree to Schedule V, line 22, col.8)			\$392,786
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			3,054
Health Care Worker Background Check (Indicate # of checks performed)	63		630
Patient Background Checks	30		300
Advertising - Promo & Yellow pages			85,930
Subscriptions			1,284
IHCA Dues			3,568
Other Licenses and Fees			1,342
Indirect Costs - See Att Sch III & Sch VI			(844)
Less: Public Relations Expense			()
Non-allowable advertising			(85,930)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$9,334
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)			0
Seminar Expense			1,225
Less: non-allowable out-of-state travel			0
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$1,225

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
See Page 21 Section F
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs
- (6)

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

\$ 28,308 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 41,610
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ None
Yes Indicate the amount. \$ 204
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
N/A

c.

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

None

d.

Have vehicle usage logs been maintained?

Yes

e.

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

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A
- (17)

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

Yes
McGladrey & Pullen, LLP
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A