

		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>0047001</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>MONTGOMERY TERRACE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-2011</u> to <u>12-31-2011</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>215 N WALNUT</u> <u>NOKOMIS</u> <u>62075</u>																									
Number City Zip Code																									
County: <u>MONTGOMERY</u>																									
Telephone Number: <u>(217) 563-7103</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>ANGELA BARR-CORNELL</u></td></tr><tr><td>(Title) <u>PRESIDENT</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>ANGELA BARR-CORNELL</u>	(Title) <u>PRESIDENT</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>ANGELA BARR-CORNELL</u>																								
	(Title) <u>PRESIDENT</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>03/06/1987</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 _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>PATRICK E. BELL, CPA</u>																									
Telephone Number: <u>(217) 465-6494</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY TERRACE

0047001 Report Period Beginning: 01-01-2011 Ending: 12-31-2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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	5,258			5,258	13
14	TOTALS	5,258			5,258	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.03%

D. How many bed-hold days during this year were paid by the Department? 582 (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 MARCH 11, 1987

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date MARCH 11, 1987 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: N/A

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

Facility Name & ID Number **MONTGOMERY TERRACE** # **0047001** Report Period Beginning: **01-01-2011** Ending: **12-31-2011**

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	21,173		1,166	22,339		22,339		22,339			1
2	Food Purchase		26,453		26,453		26,453	(270)	26,183			2
3	Housekeeping	5,612	1,752		7,364		7,364		7,364			3
4	Laundry											4
5	Heat and Other Utilities			15,489	15,489		15,489	165	15,654			5
6	Maintenance	7,135	751	5,621	13,507		13,507	123	13,630			6
7	Other (specify):*											7
8	TOTAL General Services	33,920	28,956	22,276	85,152		85,152	18	85,170			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	143,540	2,609	10,921	157,070	(2,008)	155,062		155,062			10
10a	Therapy			158	158		158		158			10a
11	Activities	8,153	2,595	1,200	11,948		11,948		11,948			11
12	Social Services											12
13	CNA Training					2,008	2,008		2,008			13
14	Program Transportation			3,990	3,990		3,990		3,990			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	151,693	5,204	21,069	177,966		177,966		177,966			16
	C. General Administration											
17	Administrative	31,237			31,237		31,237		31,237			17
18	Directors Fees											18
19	Professional Services			454	454		454		454			19
20	Dues, Fees, Subscriptions & Promotions			441	441		441		441			20
21	Clerical & General Office Expenses	5,621	478	25,210	31,309		31,309	(19,104)	12,205			21
22	Employee Benefits & Payroll Taxes			29,404	29,404		29,404	2,730	32,134			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,110	2,110		2,110		2,110			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,939	4,939		4,939		4,939			26
27	Other (specify):*											27
28	TOTAL General Administration	36,858	478	62,558	99,894		99,894	(16,374)	83,520			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	222,471	34,638	105,903	363,012		363,012	(16,356)	346,656			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			2,657	2,657		2,657	1,670	4,327			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			9,482	9,482		9,482		9,482			33
34	Rent-Facility & Grounds			50,400	50,400		50,400		50,400			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STATE INCOME TAX			400	400		400	(400)				36
37	TOTAL Ownership			62,939	62,939		62,939	1,270	64,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,777	34,777		34,777		34,777			42
43	Other (specify):*			1,608	1,608		1,608	(1,608)				43
44	TOTAL Special Cost Centers			36,385	36,385		36,385	(1,608)	34,777			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	222,471	34,638	205,227	462,336		462,336	(16,694)	445,642			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	341	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(270)	2		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	(400)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,235)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,564)		\$	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)	(14,130)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (14,130)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (16,694)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning:

Ending:

ID#

0047001

01-01-2011

12-31-2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	GIFTS	\$ (627)	21	1
2	PERSONAL SUPPLIES	(1,608)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(2,235)		49

Summary A

12-31-2011

[illegible]

Summary B

12-31-2011

[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
ANGELA BARR-CORNELL	100%	South Side Manor	Decatur	Alpha Omega	Oveido, FL	Central Office
ANGELA BARR-CORNELL	100%	Montgomery Terrace	Nokomis			
ANGELA BARR-CORNELL	100%	James R. Thompson House	Decatur			
ANGELA BARR-CORNELL	100%	Lincoln House	Lincoln			
ANGELA BARR-CORNELL	100%	East Side Terrace	Decatur			

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	21	CENTRAL OFFICE	\$ 19,680	ANGELA BARR-CORNELL		\$	(19,680)	1
2	V	5	UTILITIES				165	165	2
3	V	6	MAINTENANCE				123	123	3
4	V	21	OFFICE EXPENSE				1,203	1,203	4
5	V	22	EMPLOYEE INSURANCE				2,730	2,730	5
6	V	30	DEPRICIATION EXPENSE				1,329	1,329	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 19,680			\$ 5,550	\$ * (14,130)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY TERRACE # 0047001 Report Period Beginning: 01-01-2011 Ending: 12-31-2011

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	ANGELA BARR-CORNELL	OWNER	ADMIN-MGT	100.00	83,055	8	100.00	ADMIN-MGT	\$ 19,756	17-1	1
2	JASON CORNELL	SON OF OWNER	ADMIN		13,586	8	20.00	ADMIN	3,373	17-1	2
3	CARA EBBELER	DAUGHTER OF OW	ADMIN-CLERICAL		725	8	2.60	ADMIN-CLERIC	732	21-1	3
4	CARA EBBELER	DAUGHTER OF OW	CONSULTANT		4,800	8	17.40	CONSULTANT	1,200	11-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,061		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 MONTGOMERY TERRACE # 0047001 Report Period Beginning: 01-01-2011 Ending: 2-31-2011

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 ANGELA BARR-CORNELL
Street Address 80 ELLINGTON PLACE
City / State / Zip Code OVIEDO, FL 32765
Phone Number ()
Fax Number ()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

		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.		\$	9,400	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.)		\$	9,382	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(18)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	9,500	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.		\$	9,482	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	7,722	8	
		2007	8,307	9	
		2008	8,636	10	
		2009	9,348	11	
		2010	9,382	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,030

B. General Construction Type: Exterior BRICK/VINYL Frame WOOD/GYPSUM BO/ 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		N/A			2
3	TOTALS	#VALUE!		\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY TERRACE

#

0047001

Report Period Beginning:

01-01-2011

Ending:

12-31-2011

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10		SPRINKLER CHANGES	1987		575		10			575
11		STORAGE SHED	1987		509		10			509
12		FIRE ALARM	1989		810		10			810
13		LANDSCAPING	1990		850		10			850
14		CARPET	1992		3,597		10			3,597
15		GILLEN PROPERTIES PAINTING	1993		500		10			500
16		WALLPAPER	1995		372		10			372
17		FLOORING	1996		818		10			818
18		AIR CONDITIONER	1996		1,396		10			1,396
19		CARPET/FLOORING	1997		2,731	161	20	137	(24)	2,651
20		WINDOW AIR CONDITIONER	1998		1,647		10			1,647
21		DECK	2001		4,735	280	20	237	(43)	3,477
22		CERAMIC TILING	2003		3,963	164	20	198	34	2,899
23		RESURFACE PARKING LOT	2003		1,995	59	20	100	41	1,613
24		BATHROOM IMPROVEMENTS	2004		1,356		15	90	90	1,356
25		INTERIOR PAINTING	2005		1,895	112	20	95	(17)	944
26		BATHROOM FLOOR	2005		1,085	64	20	54	(10)	541
27		WATER TEMP REGULATOR	2005		1,441	85	20	72	(13)	718
28		SPRINKLER SYSTEM REPAIRS	2006		1,210		10	121	121	1,210
29		AUTOMATIC DOOR CLOSURE	2006		1,108		10	111	111	1,108
30		SEWER WORK	2007		4,248		20	212	212	4,248
31		ROOF	2008		9,310	339	27.5	339		1,031
32		REPAVE DRIVEWAY	2008		1,650	60	27.5	60		187
33		WATER HEATER	2010		493		15	25	25	493
34		WATER HEATER	2010		795		15	40	40	795
35		CENTRAL OFFICE						1,329	1,329	
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)		\$49,089	\$1,324		\$3,220	\$1,896	\$34,345	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Page 13

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	1,333	1,333	133	(1,200)		1,333	72
73	Fully Depreciated Assets	17,996		974	974		17,996	73
74								74
75	TOTALS	\$ 19,329	\$ 1,333	\$ 1,107	\$ (226)		\$ 19,329	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	TRANSPORTATION	2005 CHEVY VAN	2005	\$ 14,792	\$	\$	\$	5	\$ 14,792	76
77										77
78										78
79										79
80	TOTALS			\$ 14,792	\$	\$	\$		\$ 14,792	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)	\$ 83,210 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,657 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,327 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,670 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 68,466 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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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:FLORA BANK & TRUST
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:	1987	16	01/12/1987	\$ 50,400	5		3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$ 50,400			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☒ X NO Terms:

- B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)
15. Is Movable equipment rental included in building rental?☐ YES☒ X NO

16. Rental Amount for movable equipment: \$ Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning03062007

Ending03062012

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2012	\$ 50,400
13.	12/31/2013	\$ 50,400
14.	12/31/2014	\$ 50,400

* 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	\$	\$			\$	\$
2	Books and Supplies						
3	Classroom Wages (a)		336				336
4	Clinical Wages (b)		672				672
5	In-House Trainer Wages (c)		1,000				1,000
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	2,008			\$	2,008
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,008				

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
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	N/A					#VALUE!	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			\$		\$	\$		\$	#VALUE!	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 12,373	\$ 168,258	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	205,341	1,226,127	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)		190,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 217,714	\$ 1,584,385	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	49,088	315,953	15
16	Equipment, at Historical Cost	34,122	248,236	16
17	Accumulated Depreciation (book methods)	(68,466)	(511,043)	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)	\$ 14,744	\$ 53,146	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 232,458	\$ 1,637,531	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 8,173	\$ 45,124	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,642	38,314	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,075	4,760	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,500	35,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	400	801	35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 25,790	\$ 124,199	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 25,790	\$ 124,199	46
47	TOTAL EQUITY(page 18, line 24)	\$ 206,668	\$ 1,513,332	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 232,458	\$ 1,637,531	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 316,582	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 316,582	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	157,449	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	(24,555)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) INTERCOMPANY	(242,808)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (109,914)	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)	\$ 206,668	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	\$ 615,945	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 615,945	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,857	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)	\$ 3,857	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOME	(17)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (17)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 619,785	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	85,152	31
32	Health Care	177,966	32
33	General Administration	99,894	33
	B. Capital Expense		
34	Ownership	62,939	34
	C. Ancillary Expense		
35	Special Cost Centers	1,608	35
36	Provider Participation Fee	34,777	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 462,336	40
41	Income before Income Taxes (line 30 minus line 40)**	157,449	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 157,449	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31	31	5,566	179.55	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	11,526	12,160	109,937	9.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	913	913	8,153	8.93	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,295	2,295	21,173	9.23	15
16	Dishwashers					16
17	Maintenance Workers	384	416	7,135	17.15	17
18	Housekeepers	637	637	5,612	8.81	18
19	Laundry					19
20	Administrator	977	996	31,237	31.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	265	269	5,621	20.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,504	1,632	28,037	17.18	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,532	19,349	\$ 222,471 *	\$ 11.50	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	24	\$ 1,166	1-3	35
36	Medical Director	MO FEE	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	218	6,446	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	MO FEE	158	10A-3	43
44	Activity Consultant	MO FEE	1,200	11-3	44
45	Social Service Consultant				45
46	Other(specify) DENTAL	MO FEE	4,302	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	242	\$ 18,072		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		N/A		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 NumberMONTGOMERY TERRACE# 0047001Report Period Beginning: 01-01-2011Ending: 12-31-2011Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNA BRACKENBUSH	ADMIN	0	\$ 8,108
JASON CORNELL	ADMIN	0	3,373
ANGELA BARR-CORNELL	ADMIN	100	19,756
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 31,237

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
LARSSON,WOODYAR & HENSON	ACCT	\$ 454
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 454

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 7,433	
Unemployment Compensation Insurance	5,195	
FICA Taxes	16,736	
Employee Health Insurance	2,730	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
SIMPLE IRA	40	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 32,134

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	100	
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks		
LICENSES & FEES	199	
DUES & SUBSCRIPTIONS	142	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 441

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	2,032
Seminar Expense	
CPR/FIRST AID	78
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,110

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8	N/A												
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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 34,777
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? N/A
- (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. \$ N/A Has any meal income been offset against related costs? _____ 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.