

		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: 0026112

Facility Name: Moultrie County Community Center

Address: 240 East Street Lovington 61937
Number City Zip Code

County: Moultrie

Telephone Number: 217-763-2191 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 02/01/82

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
X Corporation
"Sub-S" Corp.
Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mark S. Wood, CPA Telephone Number: 217-875-2655
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 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.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) David M. Jacobus
(Title) Owner

Paid
Preparer

(Signed)
(Print Name and Title) Mark S. Wood, CPA
(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526
(Telephone) 217-875-2655 Fax # 217-875-1660

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Moultrie County Community Center # 0026112 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	20,706	3,175	1,296	25,177		25,177		25,177			1
2	Food Purchase		45,529		45,529	(4,781)	40,748		40,748			2
3	Housekeeping	30,003	3,239		33,242		33,242		33,242			3
4	Laundry		395		395		395		395			4
5	Heat and Other Utilities			18,954	18,954		18,954	3,617	22,571			5
6	Maintenance	13,681	230	7,461	21,372		21,372	52	21,424			6
7	Other (specify):*			3,593	3,593		3,593		3,593			7
8	TOTAL General Services	64,390	52,568	31,304	148,262	(4,781)	143,481	3,669	147,150			8
	B. Health Care and Programs											
9	Medical Director			7,380	7,380		7,380		7,380			9
10	Nursing and Medical Records	159,162	5,578	4,884	169,624		169,624	1,293	170,917			10
10a	Therapy			1,398	1,398		1,398		1,398			10a
11	Activities	16,493	4,551		21,044		21,044		21,044			11
12	Social Services	10,384		340	10,724		10,724		10,724			12
13	CNA Training	9,412	1,442		10,854		10,854		10,854			13
14	Program Transportation			11,247	11,247		11,247		11,247			14
15	Other (specify):*			144,049	144,049		144,049	(139,051)	4,998			15
16	TOTAL Health Care and Programs	195,451	11,571	169,298	376,320		376,320	(137,758)	238,562			16
	C. General Administration											
17	Administrative	14,882			14,882		14,882		14,882			17
18	Directors Fees											18
19	Professional Services			10,841	10,841		10,841	517	11,358			19
20	Dues, Fees, Subscriptions & Promotions			1,672	1,672		1,672		1,672			20
21	Clerical & General Office Expenses	6,500	1,762	16,640	24,902		24,902	(11,124)	13,778			21
22	Employee Benefits & Payroll Taxes			32,818	32,818	4,781	37,599		37,599			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,081	2,081		2,081		2,081			25
26	Insurance-Prop.Liab.Malpractice			9,318	9,318		9,318		9,318			26
27	Other (specify):*											27
28	TOTAL General Administration	21,382	1,762	73,370	96,514	4,781	101,295	(10,607)	90,688			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	281,223	65,901	273,972	621,096		621,096	(144,696)	476,400			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			10,621	10,621		10,621	10,802	21,423			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			917	917		917		917			32
33	Real Estate Taxes			7,473	7,473		7,473		7,473			33
34	Rent-Facility & Grounds			13,283	13,283		13,283	(13,283)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			32,294	32,294		32,294	(2,481)	29,813			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			33,389	33,389		33,389		33,389			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			33,389	33,389		33,389		33,389			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	281,223	65,901	339,655	686,779		686,779	(147,177)	539,602			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	(139,051)	15		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	3,110	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				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	(10,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,941)		\$	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)	(1,236)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,236)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (147,177)		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	Therapy		X			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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

ID#0026112

Ending:

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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	0		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
David M. Jacobus	100	Autumn Leaves, Inc. d/b/a/ Hickory Street Place	Decatur, IL	David Jacobus	Decatur, IL	Central Office
	100	Autumn Leaves, Inc. d/b/a/ Beacon Street Place	Decatur, IL	Central Office		for homes
	100	Autumn Leaves, Inc. d/b/a/ 44th Street Place	Decatur, IL			

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	General Office	\$ 1,500	David M. Jacobus, Central Office	100.00%	\$ 376	\$ (1,124)	1
2	V	5	Utilities				3,617	3,617	2
3	V	6	Maintenance				52	52	3
4	V	10	Medical Supplies				1,293	1,293	4
5	V	19	Professional Fees				517	517	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,500			\$ 5,855	\$ * 4,355	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	34	Building Rent	\$ 13,283	David M. Jacobus	100.00%	\$	(13,283)	15
16	V	30	Depreciation				7,692	7,692	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 13,283			\$ 7,692	\$ * (5,591)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	David M. Jacobus	Owner	Various	100.00	33,168	2.5	6.25	Dietary	\$ 6,500	1-1	1
2						5	12.50	Maintenance	13,681	6-1	2
3						2.5	6.25	General Office	6,500	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,681		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	<u>Moultrie County Community Center</u>
--------------------------------------	--

0026112

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

David M. Jacobus, Central Office

Street Address

2576 Greenway

City / State / Zip Code

Cerro Gordo, IL 61818

Phone Number

(217-763-2191

Fax Number

(217-763-2101

	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	21	General Office	Occupied Bed Days	9,482	2	\$ 838	\$ 0	4,259	\$ 376	1
2	5	Utilities	Occupied Bed Days	9,482	2	8,052	0	4,259	3,617	2
3	6	Maintenance	Occupied Bed Days	9,482	2	115	0	4,259	52	3
4	10	Medicla Supplies	Occupied Bed Days	9,482	2	2,879	0	4,259	1,293	4
5	19	Professional Fees	Occupied Bed Days	9,482	2	1,150	0	4,259	517	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					\$ 13,034	\$		\$ 5,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Soy Capital Bank		X	2006 Hummer H3	\$765.86	04/26/10	\$ 13,000	\$	11/26/11	7.4900	\$ 6	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	PNC Bank		X	Operating Cash	N/A	4/19/11	350,000	108,000	4/19/12	3.2500	911	6	
7												7	
8												8	
9	TOTAL Facility Related				\$765.86		\$ 363,000	\$ 108,000			\$ 917	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 363,000	\$ 108,000			\$ 917	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	8,200	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.)				\$	7,645	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(555)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	8,028	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7,473	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	7,643	8	FOR BHF USE ONLY	
		2007	7,607	9		
		2008	7,887	10		
		2009	7,944	11		
		2010	7,645	12		
2011 accrual based on 2010 taxes				13	FROM R. E. TAX STATEMENT FOR 2010	13
				14	PLUS APPEAL COST FROM LINE 5	14
				15	LESS REFUND FROM LINE 6	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Moultrie County Community Center</u>	COUNTY	<u>Moultrie</u>
FACILITY IDPH LICENSE NUMBER	<u>0026112</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>David M. Jacobus</u>		
TELEPHONE	217-763-2191	FAX #:	217-763-2101

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: 5,000

B. General Construction Type: Exterior WoodFrame Wood w/sprinklersNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Facilitiy	5,000	1994	\$ 25,000	1
2					2
3	TOTALS	5,000		\$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Moultrie County Community Center

0026112

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1994	1978	\$ 300,000	\$ 7,692	25	\$ 12,000	\$ 4,308	\$ 216,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Paint & Other Improvements			1986	1,055		19			1,055	9
10	Heating System			1986	9,876		19			9,876	10
11	Bathroom Remodel			1988	1,449	46	20		(46)	1,449	11
12	Carpet			1989	3,933		6			3,933	12
13	Roof			1990	5,700	181	20		(181)	5,700	13
14	Ramp			1988	925		20			925	14
15	Fire System			1988	1,237		20			1,237	15
16	Cabinets			1991	2,494		20	9	9	2,494	16
17	Doors			1991	1,494		26	57	57	1,200	17
18	Lights & Exhaust Fan			1991	538		16			538	18
19	Bathroom Remodel			1992	6,000	190	20	300	110	5,900	19
20	Bathroom Remodel			1992	721	23	20	36	13	712	20
21	Bathroom Remodel			1992	1,000	32	20	50	18	979	21
22	Bathroom Remodel			1992	1,030	33	20	52	19	1,011	22
23	Landscaping			1992	1,200		10			1,200	23
24	Landscaping			1992	1,200		10			1,200	24
25	Bathroom Remodel			1992	1,159	37	20	58	21	1,135	25
26	Landscaping			1992	1,700		10			1,700	26
27	Bathroom Remodel			1992	642	20	20	32	12	626	27
28	Bathroom Remodel			1992	3,100	98	20	155	57	3,023	28
29	Landscaping			1992	300		10			300	29
30	Plumbing			1992	3,045	97	25	122	25	2,335	30
31	Bathroom Remodel			1992	560	18	20	28	10	534	31
32	Plumbing			1993	1,539	49	25	62	13	1,145	32
33	Landscaping			1993	530		10			530	33
34	Carpet			1993	6,352		6			6,352	34
35	Fix Air Conditioner			1993	1,535		8			1,535	35
36											36

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Install doors & windows	1993	\$ 690	\$ 18	26	\$ 27	\$ 9	\$ 490	37
38 Doors & windows	1993	2,010	52	26	77	25	1,416	38
39 Roof	1993	7,300	187	20	365	178	6,600	39
40 Exterior painting	1994	2,725		26	105	105	1,799	40
41 Carpet	1994	2,652		6			2,652	41
42 Siding	1994	14,355	368	26	552	184	9,616	42
43 New showers	1994	735	19	20	37	18	625	43
44 Plumbing	1994	2,339	60	5		(60)	2,339	44
45 Replace light fixtures	1995	2,601		10			2,601	45
46 Carpet	1995	7,124		10			7,124	46
47 Air Conditioner	1995	1,425	37	8		(37)	1,425	47
48 Landscaping	1996	2,418	71	10		(71)	2,418	48
49 Furnace	1997	1,979	51	15	132	81	1,957	49
50 Carpet	1998	8,134		6			8,134	50
51 Carpet & linoleoum	2004	1,269		6			1,269	51
52 Roof	2007	11,300	359	10	1,130	771	3,232	52
53 TICA - HVAC	2008	2,379	61	15	159	98	568	53
54 Heating/Cooling system	2010	2,922	278	15	195	(83)	211	54
55 Alarm system	2010	3,121	80	10	312	232	494	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)		\$ 437,792	\$ 10,157		\$ 16,052	\$ 5,895	\$ 329,594	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$92,677	\$715	\$1,327	\$612	3-20 yrs	\$85,696	71
72	Current Year Purchases	1,749	1,749	184	(1,565)	7	184	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$94,426	\$2,464	\$1,511	\$(953)		\$85,880	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	Program Transportation	2006 Dodge Caravan	2006	\$17,766	\$1,701		\$(1,701)	5	\$17,765
77	Transportation	2007 Dodge Caliber	2008	13,283	1,530	3,320	1,790	5	12,453
78	Transportation	2006 Hummer (disposed)	2010		2,463	542	(1,921)	5	
79									
80	TOTALS			\$31,049	\$5,694	\$3,862	\$(1,832)		\$30,218

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)				\$588,267
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$18,315
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$21,425
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$3,110
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$445,692

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

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)				
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)	\$			

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,216	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	289,629		3
4	Supply Inventory (priced at)	3,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,259		6
7	Other Prepaid Expenses	800		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 314,904	\$	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	137,792		15
16	Equipment, at Historical Cost	125,474		16
17	Accumulated Depreciation (book methods)	(214,853)		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)	\$ 48,413	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 363,317	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 99,360	\$	26
27	Officer's Accounts Payable	15,662		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	108,000		29
30	Accrued Salaries Payable	9,480		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,204		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,027		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to related party</u>	92,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 336,733	\$	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)	\$ 336,733	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 26,584	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 363,317	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,704	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,705	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	17,879	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 17,879	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)	\$ 26,584	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	\$ 549,529	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 549,529	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	139,051	10
11	CNA Training Reimbursements	9,524	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)	\$ 148,575	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	85	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 85	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on sale of assets	9,396	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,396	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 707,585	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	148,262	31
32	Health Care	376,320	32
33	General Administration	96,514	33
	B. Capital Expense		
34	Ownership	32,294	34
	C. Ancillary Expense		
35	Special Cost Centers	33,389	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 686,779	40
41	Income before Income Taxes (line 30 minus line 40)**	20,806	41
42	Income Taxes	(2,927)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 17,879	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					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	16,381	17,188	159,162	9.26	5
6	CNA Trainees	1,083	1,083	9,412	8.69	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,708	1,708	16,493	9.66	9
10	Activity Assistants					10
11	Social Service Workers	540	540	10,384	19.23	11
12	Dietician	1,694	1,724	20,706	12.01	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	260	260	13,681	52.62	17
18	Housekeepers	3,176	3,176	30,003	9.45	18
19	Laundry					19
20	Administrator	783	783	12,802	16.35	20
21	Assistant Administrator			2,080		21
22	Other Administrative					22
23	Office Manager	130	130	6,500	50.00	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,755	26,592	\$ 281,223 *	\$ 10.58	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	37	\$ 1,296		35
36	Medical Director	Fee	7,380		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	31	1,398		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	29	1,284		43
44	Activity Consultant				44
45	Social Service Consultant	Fee	340		45
46	Other(specify) Psychologist	Fee	3,600		46
47					47
48					48
49	TOTAL (lines 35 - 48)	97	\$ 15,298		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

No

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

No

(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?

No

(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

(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
N/A

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

\$0Line

(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

(9) Are you presently operating under a sublease agreement?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YESNOX
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.
This amount is to be recorded on line 42 of Schedule V.

\$33,389

(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.

Yes

(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?
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?

\$4,781
No

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
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.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
No
100
Yes
Yes
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

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

No

(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

SEE ACCOUNTANTS' COMPILATION REPORT

Drew Corporation #0026112
d/b/a Moultrie County Community Center
December 31, 2011

Documentation - Section V, Line 7, Column 3:

Waste Removal	660
Pest Control	680
Security	2,253
	<u>3,593</u>

Documentation - Section V, Line 15, Column 3:

Workshop	139,051
Emergency Dental Care	1,573
Optical Care	35
Drugs & Medicine	3,390
	<u>144,049</u>

Documentation - Section V, Line 30, Column 7:

Depreciation - Related Party	7,692
Straight-line adjustment	3,110
	<u>10,802</u>

Reclassifications - Section V, Column 5:

	<u>From Line #</u>	<u>To Line #</u>	<u>Amount</u>
Employee Benefits (Staff Meals)	2	21	4,781

Page 7, Schedule VII, C, Related Parties
Column 5, Compensation Received from Other Homes

David Jacobus	
Autumn Leaves, Inc.	
d/b/a Hickory Street Place	
Beacon Street Place	
Decatur, Illinois	<u>33,168</u>

Section XVII, Reconciliation of Income to Taxable Income:

Net Income (Loss) Per Books	8,704
Additions:	
Federal Income Tax	-
Deductions:	
Rounding	<u>1</u>
Taxable Income	<u>8,705</u>

Section XX, General Information, Question 12:

Salary costs are allocated based upon actual hours worked.