

		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: 0045104

Facility Name: Moweaqua Nursing Home and Retirement Center

Address: 525 S Macon Street Moweaqua, IL 62550
Number City Zip Code

County: Shelby

Telephone Number: 217-768-3951 Fax # 217-768-4971

HFS ID Number:

Date of Initial License for Current Owners: 08/15/1997

Type of Ownership:

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

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ 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: Joyce Pinney Telephone Number: 217-768-3951
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 01/01/2011 to 12/31/2011 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) (Date)

(Type or Print Name) Joyce Pineey

(Title) Executive Director of Operations

Paid
Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

Facility Name & ID Number Moweaqua Nursing Home and Retirement Center

0045104 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	<u>70</u>	Skilled (SNF)	<u>70</u>	<u>25,550</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>70</u>	TOTALS	<u>70</u>	<u>25,550</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,009</u>	<u>8,895</u>		<u>18,904</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,009</u>	<u>8,895</u>		<u>18,904</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.99%

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

None (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 08/15/1997

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/15/1997 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 Fiscal Year: 12/31

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

STATE OF ILLINOIS												
Facility Name & ID Number		Moweaqua Nursing Home and Retirement Center				#	0045104	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	123,674	22,473	5,030	151,177		151,177		151,177			1
2	Food Purchase		156,624		156,624	(39,642)	116,982	(1,268)	115,714			2
3	Housekeeping	44,720	15,391	2,655	62,766		62,766		62,766			3
4	Laundry	34,988	8,299	1,879	45,166		45,166		45,166			4
5	Heat and Other Utilities			96,977	96,977	(20,705)	76,272		76,272			5
6	Maintenance	65,072	7,164	18,532	90,768	(22,973)	67,795		67,795			6
7	Other (specify):*											7
8	TOTAL General Services	268,454	209,951	125,073	603,478	(83,320)	520,158	(1,268)	518,890			8
	B. Health Care and Programs											
9	Medical Director			12,800	12,800		12,800		12,800			9
10	Nursing and Medical Records	736,260	42,068	5,117	783,445		783,445		783,445			10
10a	Therapy	39,573			39,573		39,573		39,573			10a
11	Activities	27,028	1,902	1,265	30,195		30,195		30,195			11
12	Social Services	22,820		1,518	24,338		24,338		24,338			12
13	CNA Training											13
14	Program Transportation			115	115		115		115			14
15	Other (specify):* Care Plan	33,280			33,280		33,280		33,280			15
16	TOTAL Health Care and Programs	858,961	43,970	20,815	923,746		923,746		923,746			16
	C. General Administration											
17	Administrative	167,546			167,546		167,546		167,546			17
18	Directors Fees											18
19	Professional Services			160	160		160		160			19
20	Dues, Fees, Subscriptions & Promotions			10,898	10,898		10,898	(5,565)	5,333			20
21	Clerical & General Office Expenses	22,347	14,609	30,665	67,621	(17,115)	50,506	(17,684)	32,822			21
22	Employee Benefits & Payroll Taxes			189,138	189,138		189,138		189,138			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,001	19,001		19,001		19,001			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			11,862	11,862	(3,002)	8,860		8,860			26
27	Other (specify):*											27
28	TOTAL General Administration	189,893	14,609	261,724	466,226	(20,117)	446,109	(23,249)	422,860			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,317,308	268,530	407,612	1,993,450	(103,437)	1,890,013	(24,517)	1,865,496			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			160,140	160,140	(34,189)	125,951		125,951			30
31	Amortization of Pre-Op. & Org.			9,223	9,223	(1,969)	7,254		7,254			31
32	Interest			250,702	250,702	(53,525)	197,177		197,177			32
33	Real Estate Taxes			93,816	93,816	(20,030)	73,786		73,786			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			456	456		456		456			35
36	Other (specify):* State Income Tax			544	544	(116)	428		428			36
37	TOTAL Ownership			514,881	514,881	(109,829)	405,052		405,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):* Retirement	79,016	6,602		85,618	213,266	298,884		298,884			43
44	TOTAL Special Cost Centers	79,016	6,602	38,325	123,943	213,266	337,209		337,209			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,396,324	275,132	960,818	2,632,274		2,632,274	(24,517)	2,607,757			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,268)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(17,684)	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	(5,565)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,517)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (24,517)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

Moweaqua Nursing Home and Retirement Center

Report Period Beginning:
Ending:

ID# 0045104
01/01/2011
12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Non patient meals	\$ (1,268)	2	1
2	Fines and Penalties	(17,684)	21	2
3	Marketing and Advertising	(5,565)		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	(24,517)		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
Robert C Russell	50	Pinckneyville Healthcare Center	Pinckneyville, IL			
Robert C Russell	50	Brookside Manor	Centralia, IL			
P. J. Nanavati	50	Pinckneyville Healthcare Center	Pinckneyville, IL			
P. J. Nanavati	50	Brookside Manor	Centralia, 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

X NO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Moweaqua Nursing Home and Retirement C # 0045104 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	Robert C Russell	Shareholder	Owner	50.00	None				\$ None		1
2	P J Nanavati	Shareholder	Owner	50.00	None				None		2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Moweaqua Nursing Home and Retirement Center # 0045104 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 _____
Street Address _____
City / State / Zip Code _____
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										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	INB		X	LOC	\$5,901.18	11/30/09	\$ 684,361	\$ 617,529		7.5000	\$ 39,990	1							
2	INB		X	Mortgage	\$21,558.00	05/01/04	2,969,119	2,221,036		6.2500	135,338	2							
3	INB		X	Roof Replacement	\$3,640.79		121,200	96,654		6.2500	19,237	3							
4												4							
5												5							
	Working Capital																		
6	P. J. Nanavati	X		Working Capital	None	1/1/09	492,854	882,854		0.0900	56,137	6							
7	Employee		X	Working Capital	None			35,263				7							
8												8							
9	TOTAL Facility Related					\$31,099.97		\$ 4,267,534	\$ 3,853,336			\$ 250,702	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$	\$			\$	14						
15	TOTALS (line 9+line14)							\$ 4,267,534	\$ 3,853,336			\$ 250,702	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

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.			\$	88,654	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	91,235	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,581	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	91,235	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.			\$	93,816	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	84,382	8	
		2007	84,643	9	
		2008	87,117	10	
		2009	88,654	11	
		2010	91,235	12	
		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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Moweaqua Nursing Home and Retirement Center COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0045104

CONTACT PERSON REGARDING THIS REPORT Joyce Pinney

TELEPHONE 217-768-3951 FAX #: 217-768-4971

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 1001-31-200-011	Facility	\$ 93,816.18	\$ 73,786.18
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 93,816.18	\$ 73,786.18

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000

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

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred:

131,605

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

15/10/5

3. Current Period Amortization:

8,573

4. Dates Incurred:

1997-2009

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	4.36A	1997	\$ 48,000	1
2					2
3	TOTALS	#VALUE!		\$ 48,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	70		1997	1992	\$ 3,840,750	\$ 109,736	35	\$ 109,736		\$ 1,572,879
5										
6										
7										
8										
	Improvement Type**									
9	Asphalt Paving		1998		1,100					1,100
10	Parking Lot Repaving		1998		3,450					3,450
11	Heating Systems		1999		8,266					8,266
12	Thermostat and Elements		1999		1,458					1,458
13	Carpeting		1999		20,795	1,386	15	1,386		17,040
14	Heating and Cooling Update		1999		3,632					3,632
15	Door Alarms/Telephone Panel		1999		13,659					13,659
16	Carpeting		2000		2,931	194	15	194		2,205
17	Water Heater		1998		7,491					7,491
18										
19	Loan Fees		2004		10,638	355	30	355		2,689
20										
21	Parking Lot Repaving		2007		1,500	150	10	150		700
22	Parking Lot Repaving		2008		4,887	489	10	489		1,710
23	Sprinklers		2009		5,315	483	10	483		1,208
24	Electric Fire Place		2010		523	105	5	105		209
25	Aluminum Gazebo		2010		750	125	5	125		219
26	Roof		2010		155,966	10,398	15	10,398		11,074
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,083,111	\$ 123,421		\$ 123,421	\$	\$ 1,648,989	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$599,977	\$32,933	\$32,933	\$		\$349,665	71
72	Current Year Purchases	28,398	3,201	3,201			3,201	72
73	Fully Depreciated Assets	48,281					48,281	73
74								74
75	TOTALS	\$676,656	\$36,134	\$36,134	\$		\$401,147	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	Facility Admin	1993 Ford Wagon	1997	\$1,775	\$118	\$118	\$		\$1,605	76
77	Facility Admin	1995 Dodge Caravan	1997	7,000	467	467			6,780	77
78										78
79										79
80	TOTALS			\$8,775	\$585	\$585	\$		\$8,385	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)	\$4,816,542	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$160,140	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$160,140	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,058,521	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

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: \$456
- Description: Office Equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS		(d)	
		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)	\$			

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

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

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

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

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

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

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

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

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

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

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	\$ 24,665	\$	1
2	Cash-Patient Deposits	5,921		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	621,391		3
4	Supply Inventory (priced at)	12,072		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	972,013		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,636,062	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	48,000		13
14	Buildings, at Historical Cost	3,840,750		14
15	Leasehold Improvements, at Historical Cost	211,801		15
16	Equipment, at Historical Cost	705,354		16
17	Accumulated Depreciation (book methods)	(2,058,521)		17
18	Deferred Charges	142,243		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(125,287)		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)	\$ 2,764,340	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,400,402	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 109,014	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,921		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,663		30
31	Accrued Taxes Payable (excluding real estate taxes)	289,871		31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,235		32
33	Accrued Interest Payable	134,550		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Shareholder/Employee</u>	1,384,537		36
37	<u>Accrued expenses</u>	9,660		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,115,451	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	714,183		39
40	Mortgage Payable	2,221,036		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)	\$ 2,935,219	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,050,670	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (650,268)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,400,402	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (524,353)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (524,353)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(242,261)	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)	\$ (242,261)	17
	B. Transfers (Itemize):		
18	Reversal of prior year entry for distribution that never		18
19	occurred	116,346	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 116,346	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (650,268)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,373,222	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,373,222	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,796	6
7	Oxygen	150	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,946	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,932	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,932	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	Memorials	1,914	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,914	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,390,014	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	520,158	31
32	Health Care	923,746	32
33	General Administration	446,109	33
	B. Capital Expense		
34	Ownership	405,052	34
	C. Ancillary Expense		
35	Special Cost Centers	298,884	35
36	Provider Participation Fee	38,325	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,632,274	40
41	Income before Income Taxes (line 30 minus line 40)**	(242,260)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (242,260)	43

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,160	\$ 49,420	\$ 22.88	1
2	Assistant Director of Nursing	1,315	1,315	26,291	19.99	2
3	Registered Nurses	4,161	4,217	76,745	18.20	3
4	Licensed Practical Nurses	10,105	10,315	175,346	17.00	4
5	CNAs & Orderlies	32,729	34,038	408,458	12.00	5
6	CNA Trainees					6
7	Licensed Therapist	268	272	12,262	45.08	7
8	Rehab/Therapy Aides	1,940	1,951	27,311	14.00	8
9	Activity Director	2,080	2,160	23,760	11.00	9
10	Activity Assistants	404	416	3,268	7.86	10
11	Social Service Workers	2,080	2,160	22,820	10.56	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,160	23,292	10.78	13
14	Head Cook	5,070	5,460	49,140	9.00	14
15	Cook Helpers/Assistants	3,258	3,378	28,714	8.50	15
16	Dishwashers	2,632	2,730	22,528	8.25	16
17	Maintenance Workers	4,320	4,480	65,072	14.53	17
18	Housekeepers	5,265	5,475	44,720	8.17	18
19	Laundry	4,127	4,280	34,988	8.17	19
20	Administrator	2,080	2,160	81,863	37.90	20
21	Assistant Administrator					21
22	Other Administrative	2,240	2,285	85,683	37.50	22
23	Office Manager					23
24	Clerical	1,950	1,988	22,347	11.24	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 Retirement	8,760	9,096	79,016	8.69	32
33	Other(specify) Care Plan	2,080	2,160	33,280	15.41	33
34	TOTAL (lines 1 - 33)	101,024	104,656	\$ 1,396,324 *	\$ 13.34	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	96	\$ 4,520	1,3	35
36	Medical Director	96	12,800	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,160	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,265	11,3	44
45	Social Service Consultant	48	1,518	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	384	\$ 22,263		49

C. CONTRACT NURSES

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

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

** See instructions.

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Joyce Pinney	Executive Dir		\$ 62,841	Workers' Compensation Insurance	\$	18,734	IDPH License Fee	\$ 3,980
Debra Maaks	Asst Admin		81,863	Unemployment Compensation Insurance		14,306	Advertising: Employee Recruitment	160
Christine Goldesberry-Curry	Accountant		22,842	FICA Taxes		104,264	Health Care Worker Background Check	50
				Employee Health Insurance		48,726	(Indicate # of checks performed _____)	
				Employee Meals		780	Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Publications	293
				Other Employee Benefits		2,328	Marketing Advertising	5,565
							Surety Bonds	600
TOTAL (agree to Schedule V, line 17, col. 1)							Annual Report	250
(List each licensed administrator separately.)			\$ 167,546					
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				Non-allowable advertising	(5,565)
			\$				Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$	189,138	TOTAL (agree to Sch. V,	
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
Dan Maher Law Office	Legal Fees		160					
								0
							In-State Travel	18,276
							Seminar Expense	725
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 160				line 24, col. 8)	\$ 19,001

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

N/A
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

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

5
- (6)

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

\$ 9,280

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

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

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 38,325

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

Yes

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.

\$ None

Has any meal income been offset against related costs?

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

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

25%

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

g. Does the facility transport residents to and from day training?

N/A

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?

NO

Firm Name:

N/A
- (18)

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

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.

Moweaqua Nursing and Retirement Center has a 19 bed wing for retirement residents not requiring intermediate or skilled nursing care. Full-time staff working in that wing have been segregated and reported as ancillary costs in Schedule V, as have direct supplies for that wing. Certain dietary, housekeeping, maintenance and clerical staff provide supporting services for the entire building. In addition, other costs incurred benefit both the SNF wing and the retirement wing and those costs have been allocated as follows.

Salaries and Fringe Benefits

	<u>Allocation Base</u>
Dietary - food	Patient Days
Maintenance	Patient Days
Clerical	Patient Days

Insurance Patient Days

Depreciation Building # of beds

Real Estate Taxes # of beds

Interest costs # of beds

Utilities # of beds

Patient Days are as follows for 2011:

SNF	18904	74.69%
Retirement	<u>6405</u>	25.31%
	25309	

Patient Beds are as follows:	70	78.65%
	<u>19</u>	21.35%
	89	