

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043 Report Period Beginning: 1/1/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/18/07

	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>37</u>	Skilled (SNF)	<u>37</u>	<u>13,505</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>16</u>	Intermediate (ICF)	<u>16</u>	<u>5,840</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>53</u>	TOTALS	<u>53</u>	<u>19,345</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>0</u>	<u>0</u>	<u>907</u>	<u>907</u>	8
9	SNF/PED					9
10	ICF	<u>8,641</u>	<u>3,635</u>	<u>898</u>	<u>13,174</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,641</u>	<u>3,635</u>	<u>1,805</u>	<u>14,081</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.79%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/1/1968

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 37 and days of care provided 907

Medicare Intermediary NATIONAL GOVERNMENTS SERVICES (NGS)

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 1/1/2011 Fiscal Year: 12/31/2011

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

STATE OF ILLINOIS												
Facility Name & ID Number		NEW ATHENS HOME FOR THE AGED				#	0033043	Report Period Beginning:		1/1/11	Ending:	Page 3 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	137,951			137,951	6,327	144,278		144,278			1
2	Food Purchase		90,999		90,999		90,999		90,999			2
3	Housekeeping	39,285	8,945		48,230		48,230		48,230			3
4	Laundry	72,895	11,746		84,641		84,641		84,641			4
5	Heat and Other Utilities			81,323	81,323		81,323		81,323			5
6	Maintenance	18,925	26,734		45,659		45,659		45,659			6
7	Other (specify):* KITCHEN SUPPLIES		8,174		8,174		8,174		8,174			7
8	TOTAL General Services	269,056	146,598	81,323	496,977	6,327	503,304		503,304			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	629,298	146,581		775,879	37,123	813,002		813,002			10
10a	Therapy	28,233			28,233	1,241	29,474		29,474			10a
11	Activities	33,752	2,207		35,959	852	36,811		36,811			11
12	Social Services	25,245			25,245	2,944	28,189		28,189			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* CARE PLAN COOR	38,127		137,404	175,531	(48,487)	127,044		127,044			15
16	TOTAL Health Care and Programs	754,655	148,788	137,404	1,040,847	(6,327)	1,034,520		1,034,520			16
	C. General Administration											
17	Administrative	62,698			62,698		62,698		62,698			17
18	Directors Fees											18
19	Professional Services			6,135	6,135		6,135		6,135			19
20	Dues, Fees, Subscriptions & Promotions			9,315	9,315		9,315		9,315			20
21	Clerical & General Office Expenses	37,294	10,742	8,420	56,456		56,456		56,456			21
22	Employee Benefits & Payroll Taxes			179,504	179,504		179,504		179,504			22
23	Inservice Training & Education			3,153	3,153		3,153		3,153			23
24	Travel and Seminar			2,783	2,783		2,783		2,783			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,287	50,287		50,287		50,287			26
27	Other (specify):* FINES			4,030	4,030		4,030	(4,030)				27
28	TOTAL General Administration	99,992	10,742	263,627	374,361		374,361	(4,030)	370,331			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,123,703	306,128	482,354	1,912,185		1,912,185	(4,030)	1,908,155			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			58,426	58,426		58,426		58,426			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,216	5,216		5,216		5,216			32
33	Real Estate Taxes			7,038	7,038		7,038	(7,038)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			70,680	70,680		70,680	(7,038)	63,642			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			29,018	29,018		29,018		29,018			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			29,018	29,018		29,018		29,018			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,123,703	306,128	582,052	2,011,883		2,011,883	(11,068)	2,000,815			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				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	(4,030)			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	(7,038)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (11,068)		\$	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))	\$ (11,068)		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

Report Period Beginning: ID# 0033043

Ending: 1/1/11

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
ILLINOIS SOUTH CONFERENCE OF THE UNITED CHURCH OF CHRIST	100%					

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		N/A	\$			\$	\$	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

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/11 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 _____
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	NATIONAL BANK			MORTGAGE	\$2,128.00	11/3/2011	\$ 200,000	\$ 198,844	11/3/2016	5.0000	\$ 1,762	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	THE VILLAGE BANK			WORKING CAPITAL LOC		2/17/11	150,000	150,000	2/17/12	8.0000	3,454	6	
7												7	
8												8	
9	TOTAL Facility Related				\$2,128.00		\$ 350,000	\$ 348,844			\$ 5,216	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 350,000	\$ 348,844			\$ 5,216	15	

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

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

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

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME NEW ATHENS HOME FOR THE AGED COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0033043

CONTACT PERSON REGARDING THIS REPORT GARY HOLTGREWE

TELEPHONE 618-457-2550 FAX #: ()

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:

18,230

B. General Construction Type:

ExteriorBRICK

Frame

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	40,260	1952	\$20,000	1
2	ADJACENT LOT	7,500	1986	7,000	2
3	TOTALS	47,760		\$27,000	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	11			1957	\$ 223,618	\$		\$		\$ 223,618	4
5	31			1970	320,925	8,023		8,023		315,314	5
6	11			1979	53,990	1,350		1,350		43,867	6
7				1980	97,177	2,429		2,429		76,527	7
8											8
	Improvement Type**										
9	GENERAL			1966	10,431					10,431	9
10	GENERAL			1967	6,088					6,088	10
11	GENERAL			1968	4,183					4,183	11
12	GENERAL			1972	6,897	172		172		6,587	12
13	GENERAL			1973	13,854	346		346		12,953	13
14	GENERAL			1974	4,682	117		117		4,284	14
15	GENERAL			1975	14,081	352		352		12,603	15
16	GENERAL			1976	21,994	550		550		19,245	16
17	GENERAL			1978	2,886	72		72		2,409	17
18	GENERAL			1982	4,197	105		105		3,095	18
19	GENERAL			1983	34,509	863		863		24,588	19
20	GENERAL			1984	26,999	675		675		18,561	20
21	GENERAL			1985	43,436	1,086		1,086		28,777	21
22	GENERAL			1986	72,596	1,815		1,815		46,280	22
23	GENERAL			1987	12,434	311		311		7,616	23
24	GENERAL			1990	37,580	940		940		20,199	24
25	GENERAL			1991	128,213	3,205		3,205		65,709	25
26	GENERAL			1992	52,056	1,301		1,301		25,377	26
27	GENERAL			1993	2,808	70		70		1,298	27
28	GENERAL			1994	18,866	416		416		9,517	28
29	GENERAL			1995	4,122	106		106		1,744	29
30	FOUNDATION REPAIRS			1996	15,640	401		401		6,216	30
31	KITCHEN RENOVATIONS			2001	595,899	14,897		14,897		163,872	31
32	KITCHEN RENOVATIONS			2002	44,811	1,120		1,120		10,643	32
33	DINING ROOM RENOVATIONS			2003	3,029	76		76		675	33
34	DAMPERS			2003	930	23		23		198	34
35	A/C UNITS			2003	3,968	198		198		1,033	35
36	ARCHITECT FEES			2005	4,400	110		110		678	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	2	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	ROOF REPAIR	2005	\$ 1,800	\$ 180		\$ 180		\$ 548	37
38	CONCRETE PAD	2006	16,700	418		418		2,227	38
39	HALL FLOORING	2006	3,952	99		99		519	39
40	NEW DECK & COURTYARD	2006	23,121	578		578		2,890	40
41	ENLARGE DOORWAY	2007	1,199	30		30		147	41
42	HOT WATER HEATER	2007	7,574	189		189		883	42
43	LIGHT FIXTURES	2007	548	27		27		82	43
44	LANDSCAPE	2007	2,408	121		121		502	44
45	CARPET	2007	1,406	94		94		288	45
46	3 A/C UNITS	2007	5,174	345		345		959	46
47	LIGHT FIXTURES	2008	663	33		33		97	47
48	APARTMENT CARPET	2009	1,678	112		112		249	48
49	ROOF	2009	30,570	3,057		3,057		6,496	49
50	2 A/C UNITS	2009	1,113	74		74		157	50
51	4 A/C UNITS	2009	2,310	154		154		347	51
52	80 GALLON WATER HEATER	2010	5,980	150		150		275	52
53	HAND RAIL ON RAMP	2010	7,525	188		188		251	53
54	2 ELECTRIC PANELS	2010	3,375	84		84		98	54
55	SPRINKLER SYSTEM	2010	5,500	138		138		149	55
56	AC UNIT	2010	1,595	106		106		168	56
57	2 AC UNITS	2010	1,303	87		87		123	57
58	DOOR CLOSERS	2010	727	49		49		65	58
59	3 AC UNITS	2010	5,725	382		382		509	59
60	GENERATOR	2010	17,523	438		438		438	60
61	SPRINKLER SYSTEM	2011	113,782	1,422		1,422		1,422	61
62	AC UNIT	2011	3,850	171		171		171	62
63	AC UNIT	2011	598	20		20		20	63
64	AC UNIT	2011	7,104	197		197		197	64
65	SUNROOM WINDOWS	2011	2,625	5		5		5	65
66	WATER HEATER	2011	1,052	2		2		2	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,165,779	\$ 50,079		\$ 50,079		\$ 1,194,469	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	\$ 73,676	\$ 7,601	\$ 7,601	\$		\$ 25,385	71
72	Current Year Purchases	4,798	200	200			200	72
73	Fully Depreciated Assets	372,659	545	545			372,659	73
74								74
75	TOTALS	\$ 451,133	\$ 8,346	\$ 8,346	\$		\$ 398,244	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,643,912	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,425	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,425	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)	\$ 1,592,713	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	6 ASSISTED LIVING UNITS	\$ 253,710	\$ 6,343	\$ 127,912	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 253,710	\$ 6,343	\$ 127,912	91

G. Construction-in-Progress

	Description	Cost	
92	CONSTRUCTION IN PROG	\$ 3,800	92
93			93
94			94
95		\$ 3,800	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: NONE
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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

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

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

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

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	\$ 85,301	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	528,031		3
4	Supply Inventory (priced at)	10,429		4
5	Short-Term Investments	2,100		5
6	Prepaid Insurance	14,628		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 640,489	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,000		13
14	Buildings, at Historical Cost	2,423,289		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	451,133		16
17	Accumulated Depreciation (book methods)	(1,720,626)		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)	\$ 1,180,796	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,821,285	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 47,313	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,500		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,730		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	CURRENT PORTION OF LT DEBT	165,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 265,543	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	183,844		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)	\$ 183,844	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 449,387	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,371,898	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,821,285	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$1,524,132	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$1,524,132	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(152,234)	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)	\$(152,234)	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)	\$1,371,898	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	\$ 1,797,653	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,797,653	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,277	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,277	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	34,469	24
25	Interest and Other Investment Income***	692	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,161	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET RENTAL INCOME	23,558	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,558	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,859,649	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	496,977	31
32	Health Care	1,040,847	32
33	General Administration	374,361	33
	B. Capital Expense		
34	Ownership	70,680	34
	C. Ancillary Expense		
35	Special Cost Centers	29,018	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)*	\$ 2,011,883	40
41	Income before Income Taxes (line 30 minus line 40)**	(152,234)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (152,234)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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	2,027	2,080	\$ 59,660	\$ 28.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,290	2,370	52,902	22.32	3
4	Licensed Practical Nurses	13,240	13,888	237,233	17.08	4
5	CNAs & Orderlies	28,003	29,405	279,503	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,145	2,453	28,233	11.51	8
9	Activity Director	1,975	2,207	33,752	15.29	9
10	Activity Assistants					10
11	Social Service Workers	1,688	1,904	25,245	13.26	11
12	Dietician					12
13	Food Service Supervisor	1,825	2,041	28,869	14.14	13
14	Head Cook	2,882	3,114	31,093	9.98	14
15	Cook Helpers/Assistants	3,006	3,310	34,404	10.39	15
16	Dishwashers	4,199	4,639	43,585	9.40	16
17	Maintenance Workers	1,526	1,622	18,925	11.67	17
18	Housekeepers	3,946	4,290	39,285	9.16	18
19	Laundry	5,846	6,790	72,895	10.74	19
20	Administrator	1,911	2,080	62,698	30.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,864	2,080	37,294	17.93	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) CARE PLAN CO	1,953	2,169	38,127	17.58	33
34	TOTAL (lines 1 - 33)	80,326	86,442	\$ 1,123,703 *	\$ 13.00	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	99	\$ 6,327		35
36	Medical Director	12	6,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,640		39
40	Physical Therapy Consultant	17	1,241		40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	852		44
45	Social Service Consultant	83	2,944		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	283	\$ 20,004		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	65	2,292		51
52	Certified Nurse Assistants/Aides	1,234	26,191		52
53	TOTAL (lines 50 - 52)	1,299	\$ 28,483		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberNEW ATHENS HOME FOR THE AGED# 0033043Report Period Beginning: 1/1/11Ending: 12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GARY HOLTGREWE	ADMINISTRATOR		\$ 62,698
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,698

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MOORE, RENNER & SIMONIN	AUDIT	\$ 4,975
GREENSFELDER	LEGAL	430
MICHIGAN PEER REVIEW ORG	LEGAL	730
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 6,135

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 84,998	
Unemployment Compensation Insurance	5,239	
FICA Taxes	85,575	
Employee Health Insurance	233	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
UNIFORMS	3,459	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 179,504

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$ 1,990	
Advertising: Employee Recruitment	5,641	
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks	1,584	
BONDS	100	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,315

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,783
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,783

* 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?

YES

If YES, give association name and amount.

IDPH 1,990

(3)

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

NO

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

(4)

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

NO

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

YES

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

10 YEARS

(6)

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

\$

N/A

Line

(7)

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

YES

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

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

YES

NO

X

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

(11)

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

\$

29,018

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?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

N/A

Has any meal income been offset against related costs?

Indicate the amount.

\$

(16)

Travel and Transportation

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

NO

If YES, attach a complete explanation.

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

NO

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

\$

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

0

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A

(17)

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

YES

Firm Name:

MOORE, RENNER & SIMONIN, P.C.

(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.

NEW ATHENS HOME FOR THE AGED
SCHEDULE OF RECLASSIFICATIONS ON PAGES 3&4
2011

	LINE#		
DIETARY	1	6,327	
NURSING AND MEDICAL RECORDS	10	37,123	
THERAPY	10a	1,241	
ACTIVITIES	11	852	
SOCIAL SERVICES	12	2,944	
OTHER	15		48,487