

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0040626</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Peachtree Estates</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2010</u> to <u>June 30, 2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>1370 State Route 127 South</u> <u>Jonesboro</u> <u>62952</u>			
NumberCityZip Code			
County: <u>Union</u>			
Telephone Number: <u>(618) 833-5344</u> Fax # <u>(618) 833-8217</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>03/21/95</u>			
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 _____			

Facility Name & ID Number	Peachtree Estates
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0040626 Report Period Beginning: July 1, 2010 Ending: June 30, 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

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

29 (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)

F. Does the facility maintain a daily midnight census?

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

I. On what date did you start providing long term care at this location?

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

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

ACCRUAL	☐	MODIFIED CASH*	☐	CASH*	☐
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Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: Fiscal Year:

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

1		2		3		4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period			
1		Skilled (SNF)				1	
2		Skilled Pediatric (SNF/PED)				2	
3		Intermediate (ICF)				3	
4		Intermediate/DD				4	
5		Sheltered Care (SC)				5	
6	16	ICF/DD 16 or Less	16	5,840		6	
7	16	TOTALS	16	5,840		7	

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,994			4,994	13
14	TOTALS	4,994			4,994	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.51%

Facility Name & ID Number Peachtree Estates # 0040626 Report Period Beginning: July 1, 2010 Ending: June 30, 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	43,233	811	2,241	46,285		46,285		46,285			1
2	Food Purchase		32,935		32,935		32,935		32,935			2
3	Housekeeping	25,216	1,699		26,915		26,915		26,915			3
4	Laundry	9,606	832		10,438		10,438		10,438			4
5	Heat and Other Utilities			12,125	12,125		12,125		12,125			5
6	Maintenance		4,916	12,814	17,730		17,730		17,730			6
7	Other (specify):*											7
8	TOTAL General Services	78,055	41,193	27,180	146,428		146,428		146,428			8
	B. Health Care and Programs											
9	Medical Director			1,793	1,793		1,793		1,793			9
10	Nursing and Medical Records	176,890	11,402	69,864	258,156		258,156		258,156			10
10a	Therapy			4,506	4,506		4,506		4,506			10a
11	Activities	118	225	520	863		863		863			11
12	Social Services											12
13	CNA Training	3,438		1,200	4,638		4,638		4,638			13
14	Program Transportation		4,445	4,319	8,764		8,764		8,764			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	180,446	16,072	82,202	278,720		278,720		278,720			16
	C. General Administration											
17	Administrative	56,406		18,000	74,406		74,406	1,000	75,406			17
18	Directors Fees											18
19	Professional Services			27,522	27,522		27,522		27,522			19
20	Dues, Fees, Subscriptions & Promotions			2,917	2,917		2,917		2,917			20
21	Clerical & General Office Expenses	3,462	2,277	6,583	12,322		12,322		12,322			21
22	Employee Benefits & Payroll Taxes			45,011	45,011		45,011		45,011			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,045	1,045		1,045		1,045			24
25	Other Admin. Staff Transportation			1,012	1,012		1,012	192	1,204			25
26	Insurance-Prop.Liab.Malpractice			6,350	6,350		6,350		6,350			26
27	Other (specify):*											27
28	TOTAL General Administration	59,868	2,277	108,440	170,585		170,585	1,192	171,777			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	318,369	59,542	217,822	595,733		595,733	1,192	596,925			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			14,830	14,830		14,830		14,830			30
31	Amortization of Pre-Op. & Org.			2,342	2,342		2,342		2,342			31
32	Interest			16,957	16,957		16,957		16,957			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			34,129	34,129		34,129		34,129			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			38,268	38,268		38,268		38,268			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,268	38,268		38,268		38,268			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	318,369	59,542	290,219	668,130		668,130	1,192	669,322			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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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))	\$		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

Peachtree Estates

ID# 0040626

Report Period Beginning: July 1, 2010

Ending: June 30, 2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Related party management fee	\$ 1,000	17	1
2	commuting vehicle expense	192	25	2
3	commuting portion of depreciation	0		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	1,192		49

Summary A

June 30, 2011

[illegible]

Summary B

June 30, 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

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		Management fee	\$ 18,000	RAVE, Inc.	100.00%	\$ 17,000	\$ (1,000)	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			\$ 18,000			\$ 17,000	\$ * (1,000)	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 Peachtree Estates # 0040626 Report Period Beginning: July 1, 2010 Ending: ne 30, 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	IDFA Pooled Loan		x	building & equipment	\$4,017.00	03/01/95	\$	239,805	07/04/14	0.0495	\$ 14,540	1
2	AJ National Bank		x	auto loans		various		5,162			2,353	2
3												3
4												4
5												5
	Working Capital											
6	Credit cards & suppliers		x	accounts payable							64	6
7												7
8												8
9	TOTAL Facility Related				\$4,017.00		\$	244,967			\$ 16,957	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$	244,967			\$ 16,957	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.)

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

B. Real Estate Taxes

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

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	<u>Peachtree Estates</u>	COUNTY	<u>Union</u>
---------------	--------------------------	--------	--------------

FACILITY IDPH LICENSE NUMBER 0040626

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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?

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: 4,560

B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

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

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

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	<u>facility</u>	<u>60,000</u>	<u>1994</u>	<u>\$ 43,586</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	60,000		\$ 43,586	3

Facility Name & ID Number Peachtree Estates

0040626

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1995	1995	\$ 408,923	\$ 8,178	50	\$ 8,178	\$	\$ 134,943	4
5			1995	1995	2,484	81	15	81		2,484	5
6			1996	1996	1,240		10			1,240	6
7											7
8											8
	Improvement Type**										
9	carpet & tile		1996		5,540	370	15	370		5,358	9
10	tile base & rooms		1998		2,512		15			2,512	10
11	driveway		2006		2,594		15			2,594	11
12	driveway		1999		976	65	15	65		775	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

*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)		\$ 424,269	\$ 8,694		\$ 8,694	\$	\$ 149,906	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	\$ 69,039	\$ 1,540	\$ 1,540	\$	7	\$ 62,938	71
72	Current Year Purchases	904	129	129		7	129	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 69,943	\$ 1,669	\$ 1,669	\$		\$ 63,067	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient	2006 Pontiac Montana	2008	\$ 17,500	\$ 4,667	\$ 4,667	\$	3	\$ 16,335	76
77										77
78										78
79										79
80	TOTALS			\$ 17,500	\$ 4,667	\$ 4,667	\$		\$ 16,335	80

E. Summary of Care-Related Assets

	1 Reference	2 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)	\$ 555,298	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,030	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,030	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)	\$ 229,308	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:
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

☐

☐

☒

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$ 100	\$ 1,925	\$	\$ 2,025
2	Books and Supplies	40	400		440
3	Classroom Wages (a)	330	3,630		3,960
4	Clinical Wages (b)		7,260		7,260
5	In-House Trainer Wages (c)	344	3,438		3,782
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 814	\$ 16,653	\$	\$ 17,467
10	SUM OF line 9, col. 1 and 2 (e)	\$ 17,467			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,095	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	134,907		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,273		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)	\$ 159,275	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,586		13
14	Buildings, at Historical Cost	424,269		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	87,443		16
17	Accumulated Depreciation (book methods)	(229,308)		17
18	Deferred Charges	7,025		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)	\$ 333,015	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 492,290	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 141,072	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,162		29
30	Accrued Salaries Payable	13,964		30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,948)		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 157,250	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	239,805		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)	\$ 239,805	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 397,055	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 95,235	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 492,290	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 123,977	1
2	Restatements (describe):		2
3	audit adjustments	(36,477)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 87,500	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,735	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)	\$ 7,735	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)	\$ 95,235	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.

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 675,835	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 675,835	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		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		24
25	Interest and Other Investment Income***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 675,865	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	146,428	31
32	Health Care	278,720	32
33	General Administration	170,585	33
	B. Capital Expense		
34	Ownership	34,129	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,268	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 668,130	40
41	Income before Income Taxes (line 30 minus line 40)**	7,735	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,735	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

STATE OF ILLINOIS

Facility Name & ID Number Peachtree Estates

0040626

Report Period Beginning: July 1, 2010 Ending:

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12	12	118	9.83	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,146	3,455	43,233	12.51	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,590	2,846	25,216	8.86	18
19	Laundry	988	1,085	9,606	8.85	19
20	Administrator	743	816	15,692	19.23	20
21	Assistant Administrator	936	1,029	17,409	16.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	314	346	3,462	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,429	1,570	23,305	14.84	29
30	Habilitation Aides (DD Homes)	18,368	19,965	176,890	8.86	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>CNA Trainer</u>	156	172	3,438	19.99	33
34	TOTAL (lines 1 - 33)	28,682	31,296	\$ 318,369 *	\$ 10.17	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period
35	Dietary Consultant	35	\$ 2,241
36	Medical Director	12	1,793
37	Medical Records Consultant		
38	Nurse Consultant		
39	Pharmacist Consultant	3	340
40	Physical Therapy Consultant		
41	Occupational Therapy Consultant		
42	Respiratory Therapy Consultant		
43	Speech Therapy Consultant	11	770
44	Activity Consultant		
45	Social Service Consultant		
46	Other(specify) <u>Psychologist</u>	33	2,440
47			
48			
49	TOTAL (lines 35 - 48)	94	\$ 7,584

C. CONTRACT NURSES

		1	2
		Number of Hrs. Paid & Accrued	Total Contract Wages
50	Registered Nurses		\$
51	Licensed Practical Nurses	2,420	48,307
52	Certified Nurse Assistants/Aides		
53	TOTAL (lines 50 - 52)	2,420	\$ 48,307

3

Schedule V Line & Column Reference	
	35
	36
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3

Schedule V Line & Column Reference	
	50
	51
	52
	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Gary Griffith	Administrator		\$ 15,692	Workers' Compensation Insurance		\$ 10,410	IDPH License Fee		\$
Joan Patton	Asst. Admin.		17,409	Unemployment Compensation Insurance		12,000	Advertising: Employee Recruitment		2,284
Various	RSD		23,305	FICA Taxes		22,330	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance			Loan fees and bank charges		381
				Employee Meals			Other Licenses & Fees		217
				Illinois Municipal Retirement Fund (IMRF)*					35
				Medical fees		271			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 56,406						
B. Administrative - Other							Less: Public Relations Expense		()
Description			Amount				Non-allowable advertising		()
			\$				Yellow page advertising		()
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,917
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 45,011			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount
Aschemann Keller	Legal		\$ 4,040			\$	Out-of-State Travel		\$
Stratton, Giganti Et Al	Legal		14,136						
Beussink & Hickam	CPA		9,346				In-State Travel		
							Seminar Expense		
							Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 27,522	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

no

(2)

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

no

(3)

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

no

(4)

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

no

(5)

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

yes

(6)

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

\$ 2,322 Line 10

(7)

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

yes

(8)

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

no

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

\$ 38,268

(12)

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

no
- (13)

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

yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

no

(15)

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

\$ 0
no

(16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

no
no
100%
yes
yes
yes

g.

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

no

(17)

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

will be
Beussink & Hickam

(18)

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

yes

(19)

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

yes