

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0018044</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>PRAIRIEVIEW LUTHERAN HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</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>PO BOX 4</u> <u>DANFORTH</u> <u>60930</u>																																																			
Number City Zip Code																																																			
County: <u>IROQUOIS</u>																																																			
Telephone Number: <u>815-269-2970</u> Fax # <u>815-269-2930</u>																																																			
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>KAREN SIPPEL</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>ADMINISTRATOR</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>SHERILYN K RABIDEAU</u> <u>CPA</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>FOX CPA GROUP, LTD</u> <u>204 E CHERRY STREET, SUITE 300, WATSEKA, IL 60970</u></td><td></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>KAREN SIPPEL</u>		Paid Preparer	(Title) <u>ADMINISTRATOR</u>		(Signed) _____	(Date) _____	(Print Name and Title) <u>SHERILYN K RABIDEAU</u> <u>CPA</u>		(Firm Name & Address) <u>FOX CPA GROUP, LTD</u> <u>204 E CHERRY STREET, SUITE 300, WATSEKA, IL 60970</u>																																			
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Date of Initial License for Current Owners: <u>02/14/74</u>		(Telephone) <u>815-432-3126</u> Fax # <u>815-432-6061</u>																																																	
Type of Ownership:		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																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 C (3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 C (3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____			
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		☐	Trust	_____																																															
		☐	Other _____	_____																																															
In the event there are further questions about this report, please contact:																																																			
Name: <u>KAREN SIPPEL</u>		Telephone Number: <u>815-269-2970</u>																																																	
Email Address: _____		_____																																																	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number	PRAIRIEVIEW LUTHERAN HOME
--------------------------------------	----------------------------------

0018044 Report Period Beginning: 01/01/11 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

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)**

OUTPATIENT THERAPY, DAY CARE

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?

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 2/14/74

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 20 and days of care provided 1,755

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL	X	MODIFIED CASH*		CASH*	
---------	---	----------------	--	-------	--

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

Tax Year: 12/31/11 **Fiscal Year:** 12/31/11

* 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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	6,171	22,185	1,755	30,111	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,171	22,185	1,755	30,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.66%

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **PRAIRIEVIEW LUTHERAN HOME** # **0018044** Report Period Beginning: **1/1/2011** 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	400,023	28,750	8,199	436,972		436,972		436,972			1
2	Food Purchase		253,927		253,927	(11,548)	242,379		242,379			2
3	Housekeeping	168,180	46,322		214,502		214,502		214,502			3
4	Laundry	88,030	12,326		100,356		100,356		100,356			4
5	Heat and Other Utilities			104,986	104,986		104,986		104,986			5
6	Maintenance	117,719	7,684	50,746	176,149		176,149		176,149			6
7	Other (specify):* MEDICAL WASTE					8,821	8,821		8,821			7
8	TOTAL General Services	773,952	349,009	163,931	1,286,892	(2,727)	1,284,165		1,284,165			8
	B. Health Care and Programs											
9	Medical Director			14,097	14,097	(9,298)	4,799		4,799			9
10	Nursing and Medical Records	2,332,400	236,861	19,978	2,589,239	(15,569)	2,573,670	(17,293)	2,556,377			10
10a	Therapy			322,367	322,367	442	322,809	(18,670)	304,139			10a
11	Activities	229,201	4,390	4,743	238,334		238,334		238,334			11
12	Social Services	45,224	147	1,679	47,050		47,050		47,050			12
13	CNA Training											13
14	Program Transportation					1,163	1,163		1,163			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,606,825	241,398	362,864	3,211,087	(23,262)	3,187,825	(35,963)	3,151,862			16
	C. General Administration											
17	Administrative	71,360			71,360		71,360		71,360			17
18	Directors Fees											18
19	Professional Services			76,644	76,644		76,644	(26,475)	50,169			19
20	Dues, Fees, Subscriptions & Promotions			50,213	50,213	1,793	52,006	(46,725)	5,281			20
21	Clerical & General Office Expenses	258,209	24,268	105,701	388,178	(5,025)	383,153	(5,726)	377,427			21
22	Employee Benefits & Payroll Taxes			1,110,547	1,110,547	30,384	1,140,931		1,140,931			22
23	Inservice Training & Education					3,474	3,474		3,474			23
24	Travel and Seminar			18,285	18,285	(4,637)	13,648	(1,873)	11,775			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,971	36,971		36,971		36,971			26
27	Other (specify):*											27
28	TOTAL General Administration	329,569	24,268	1,398,361	1,752,198	25,989	1,778,187	(80,799)	1,697,388			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,710,346	614,675	1,925,156	6,250,177		6,250,177	(116,762)	6,133,415			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			189,451	189,451		189,451		189,451			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			189,451	189,451		189,451		189,451			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			25,572	25,572		25,572		25,572			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			74,847	74,847		74,847		74,847			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,710,346	614,675	2,189,454	6,514,475		6,514,475	(116,762)	6,397,713			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(18,670)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,293)	10		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	(26,475)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,726)	21		24
25	Fund Raising, Advertising and Promotional	(44,050)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,675)	20		28
29	Other-Attach Schedule TRAVEL	(1,873)	24		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,762)		\$	30

BHF USE ONLY							
48		49		50		51	

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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (116,762)		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		X			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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: ID# 0018044

Ending: 01/01/11

12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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
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19				19
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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
N/A						

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			\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	N/A								\$		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/2011 Ending: #####

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	N/A					\$	\$			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				N/A			\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	N/A		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).		\$	#VALUE!		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.		\$	#VALUE!		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>PRAIRIEVIEW LUTHERAN HOME</u>	COUNTY	<u>IROQUOIS</u>
---------------	----------------------------------	--------	-----------------

FACILITY IDPH LICENSE NUMBER 0018044

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</u> <u>Applicable to</u> <u>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: 49,200

B. General Construction Type: Exterior BRICKFrame STEEL & BRICKNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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: 1,189

2. Number of Years Over Which it is Being Amortized: 30

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	BLDG/GROUNDS	304,920	1971	\$ 9,115	1
2					2
3	TOTALS	304,920		\$ 9,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	60			1973	\$ 649,963	\$ 13,749	40	\$ 13,749	\$	\$ 521,742
5				1995	1,011,406	25,285	40	25,285		420,040
6	32			1996	1,834,874	45,872	40	45,872		672,792
7										
8										
	Improvement Type**									
9	FULLY DEPRECIATED				381,514					381,514
10	RENOVATING-NURSES STATION			1989	137,205		VARIOUS			137,205
11	REMODELING			1991	3,303	132	25	132		2,744
12	PARKING LOT/SIDEWALK			1993	19,868					19,868
13	TREATMENT PLANT			1994	225,522	11,276	20	11,276		193,572
14	1996 IMPROVEMENTS			1996	43,886	840	VARIOUS	840		25,655
15	1995 IMPROVEMENTS			1995	148,653	5,617	VARIOUS	5,617		127,443
16	1997 IMPROVEMENTS			1997	141,536					141,536
17	1998 IMPROVEMENTS			1998	72,034	4,491	VARIOUS	4,491		61,785
18	RISER/SEAL TREATMENT PLANT			2002	1,090	73	15	73		730
19	2003 IMPROVEMENTS			2003	116,240	2,460	VARIOUS	2,460		33,658
20	2004 IMPROVEMENTS			2004	31,669	722	VARIOUS	722		5,730
21	SIGN			2005	8,900	593	15	593		3,805
22	WATER SOFTNER			2005	9,667	967	10	967		6,124
23	FLOORING			2005	655	44	15	44		271
24	CEILING TILE FOR KITCHEN			2005	948	47	20	47		290
25	FLOORING IN 4 ROOMS			2005	3,770	189	20	189		1,134
26	FLOORING IN SHOWERS			2006	7,400	493	15	493		2,876
27	LOFT IN GARAGE			2006	580	15	40	15		85
28	FLOORING IN CLOSETS			2006	1,000	67	15	67		374
29	COUNTERTOP AND STORAGE BOXES			2007	1,197	80	15	80		387
30	HVAC SYSTEM			2007	121,775	6,089	20	6,089		25,371
31	FLOORING-FAITH PLACE			2007	52,500	3,500	15	3,500		15,750
32	PARKING LOT			2008	9,500	475	20	475		1,583
33	COUNTEROP NURSES STATION			2008	2,999	300	10	300		1,075
34	DOOR/FRAME KITCHEN			2008	2,275	114	20	114		408
35	RTU 12'T CARRIER ROOF TOP			2008	13,049	652	20	652		2,282
36	DOOR FRAME GUIDES			2008	1,353	68	20	68		360

*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

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 LCN CLOSURE ALARM PATIO	2008	\$ 1,750	\$ 88	20	\$ 88	\$	\$ 293	37
38 HVAC VENTILATION SYSTEM	2008	83,299	2,082	40	2,082		6,593	38
39 TUB/SHOWER ROOM(CONTRACTED TOTAL)	2009	153,707	3,843	40	3,843		8,006	39
40 FIRE ALARM SYSTEM	2009	16,500	413	40	413		1,135	40
41 SPA TUB	2009	17,472	437	40	437		1,020	41
42 WINDOW SASHES	2009	1,381	138	10	138		334	42
43 ROOF TOP COMPRESSOR	2009	2,290	229	10	229		515	43
44 NEW ASPHALT	2009	7,780	389	20	389		940	44
45 SWITCH ASSEMBLIES FOR KOHLER GENE	2010	1,066	27	40	27		45	45
46 BATHROOM TILE	2010	680	17	40	17		28	46
47 NEW ROOF	2010	250,056	6,251	40	6,251		8,856	47
48 NEW FRONT SLOPED ROOF	2010	2,820	71	40	71		100	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)		\$ 5,595,132	\$ 138,195		\$ 138,195	\$	\$ 2,836,054	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 260,670	\$ 42,369	\$ 42,369	\$	10	\$ 167,220	71
72	Current Year Purchases	42,119	653	653		10	653	72
73	Fully Depreciated Assets	632,423					632,423	73
74								74
75	TOTALS	\$ 935,212	\$ 43,022	\$ 43,022	\$		\$ 800,296	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	RES TRANSPORTATION	2010 FORD ELKHART	2010	\$ 45,949	\$ 4,595	\$ 4,595	\$	10	\$ 7,275
77	RES TRANSPORTATION	2007 FORD CONV VAN	2010	36,393	3,639	3,639		10	4,246
78									
79									
80	TOTALS			\$ 82,342	\$ 8,234	\$ 8,234	\$		\$ 11,521

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)			\$ 6,621,801
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 189,451
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 189,451
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 3,647,871

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	LAND DONATED TO BE USED	\$ 35,540	\$	\$
87	FOR EXPANSION			
88				
89				
90				
91	TOTALS	\$ 35,540	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	ARCHITECT AND FEES	\$ 11,253
93		
94		
95		\$ 11,253

* 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:	N/A			\$			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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

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

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	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	\$	1,493	\$ 124,267	\$ 272	1,493	\$ 124,539	1
2	Licensed Speech and Language Development Therapist		hrs		266	24,795		266	24,795	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,196	174,040	171	2,196	174,211	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
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,955	\$ 323,102	\$ 443	3,955	\$ 323,545	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits	180,063		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	809,476		3
4	Supply Inventory (priced at COST)	29,287		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,362		6
7	Other Prepaid Expenses	14,172		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM OTHER FUNDS	43,202		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,089,562	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,655		13
14	Buildings, at Historical Cost	5,064,676		14
15	Leasehold Improvements, at Historical Cost	269,080		15
16	Equipment, at Historical Cost	1,290,183		16
17	Accumulated Depreciation (book methods)	(3,647,871)		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)	\$ 3,020,723	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,110,285	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 227,600	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	64,065		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,591		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	DEFERRED REVENUE	374,364		36
37	OTHER ACCRUED EXPENSES	34,888		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 887,508	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 887,508	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,222,777	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,110,285	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,568,314	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,568,314	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(426,444)	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)	\$ (426,444)	17
	B. Transfers (Itemize):		
18	FOUNDATION TRANSFERS	80,907	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 80,907	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,222,777	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,875,902	1
2	Discounts and Allowances for all Levels	(487,415)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,388,487	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	631,699	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 631,699	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	24,929	13
14	Non-Patient Meals	17,854	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)	\$ 42,783	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,603	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,603	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>SUI/OTHER</u>	23,459	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,459	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,088,031	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,286,892	31
32	Health Care	3,211,087	32
33	General Administration	1,752,198	33
	B. Capital Expense		
34	Ownership	189,451	34
	C. Ancillary Expense		
35	Special Cost Centers	25,572	35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,514,475	40
41	Income before Income Taxes (line 30 minus line 40)**	(426,444)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (426,444)	43

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,840	2,080	\$ 64,890	\$ 31.20	1
2	Assistant Director of Nursing	3,965	4,435	115,399	26.02	2
3	Registered Nurses	14,377	15,363	357,159	23.25	3
4	Licensed Practical Nurses	26,019	28,552	559,507	19.60	4
5	CNAs & Orderlies	94,587	102,757	1,146,953	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,858	2,113	21,125	10.00	8
9	Activity Director	1,692	1,872	43,106	23.03	9
10	Activity Assistants	16,426	17,774	188,924	10.63	10
11	Social Service Workers	1,800	2,080	36,607	17.60	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	40,356	19.40	13
14	Head Cook	6,080	6,887	85,919	12.48	14
15	Cook Helpers/Assistants	28,219	30,739	273,748	8.91	15
16	Dishwashers					16
17	Maintenance Workers	5,153	5,800	117,719	20.30	17
18	Housekeepers	14,860	16,520	168,180	10.18	18
19	Laundry	8,005	8,717	88,030	10.10	19
20	Administrator	1,472	1,664	71,360	42.88	20
21	Assistant Administrator					21
22	Other Administrative	8,726	9,760	201,237	20.62	22
23	Office Manager					23
24	Clerical	8,581	9,255	120,179	12.99	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	845	848	9,948	11.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	246,345	269,296	\$ 3,710,346 *	\$ 13.78	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	152	\$ 8,199	1-3	35
36	Medical Director	192	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	117	5,828	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	24	1,694	11-3	44
45	Social Service Consultant	24	1,679	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	509	\$ 22,200		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. 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
KAREN SIPPEL	ADMIN		\$ 71,360	Workers' Compensation Insurance	\$	189,664	IDPH License Fee	\$ 1,907
				Unemployment Compensation Insurance		5,965	Advertising: Employee Recruitment	1,078
				FICA Taxes		277,622	Health Care Worker Background Check	
				Employee Health Insurance		582,833	(Indicate # of checks performed 43)	1,133
				Employee Meals		17,854	Patient Background Checks	66
				Illinois Municipal Retirement Fund (IMRF)*			VIEWS	9,963
				MEDICAL REIMBURSEMENT PLAN		10,608	SUBSCRIPTIONS	2,237
				EMPLOYEE PHYSICALS		9,268	DUES	11,028
				INCENTIVES		3,262	PROMOTION	24,000
				PENSION		43,855	NONDEDUCTIBLE DUES	(3,990)
							Less: Public Relations Expense	(33,963)
							Non-allowable advertising	(6,097)
							Yellow page advertising	(2,675)
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)				\$ 1,140,931			\$ 5,281	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
				Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$ 499
							In-State Travel	2,867
							LESS IN SERVICE	(3,474)
							Seminar Expense	14,591
							OUT OF STATE SEMINAR	328
							NON ALLOWABLE	(1,873)
							NURSING TRAVEL	(1,163)
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL		\$	TOTAL	\$ 11,775
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
DECK & BARON	LEGAL		\$ 442					
DUANE MORRIS LLP	LEGAL		21,713					
FOX CPA GROUP	AUDIT		5,340					
KELLY, COX, POTTER & CO	ACCOUNTANTS		9,772					
RITA FINK	ACCOUNTANTS		11,676					
BENEFIT PLANNING CONS	FLEX/HRA PLAN ADMIN		3,075					
CLIFTON GUNDERSON LLC	401K PENSION AUDIT		8,180					
FRANK SIMUTIS PC	5500 SF PREP/403 B		6,998					
FR&R HEALTH CARE CONS	MEDICARE COST RPT		4,575					
SMITH AMUNDSON LLC	EMPLOYEE HANDBOOK		3,675					
MICHAEL H COHEN	EMPLOYEE ISSUES		624					
OTHER LESS THAN \$500	PLAN ADMIN		574					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 76,644								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN \$3397/LSI 870/AAHSA 2084

(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 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 64,608 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. _____

(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. \$ 49,275
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. \$ 17,854 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
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? 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? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FOX CPA GROUP, LTD

(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? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT