

		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>0038653</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>WOODSTOCK RESIDENCE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/11</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>309 MCHENRY AVENUE</u> <u>WOODSTOCK</u> <u>60098</u>																									
Number City Zip Code																									
County: <u>MCHENRY</u>																									
Telephone Number: <u>(815) 338-1700</u> Fax # <u>(815) 338-1765</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td></tr><tr><td>(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>												
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	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>																								
Date of Initial License for Current Owners: <u>2/1/93</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>DARRYL BUEKER</u> Telephone Number: <u>(417) 865-8701</u> Email Address: _____																									

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653 Report Period Beginning: 1/1/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>41,975</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>41,975</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>23,115</u>	<u>3,171</u>	<u>6,037</u>	<u>32,323</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,115</u>	<u>3,171</u>	<u>6,037</u>	<u>32,323</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.01%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

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

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

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

I. On what date did you start providing long term care at this location? Date started 2/1/93

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 2/1/93 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 29 and days of care provided 3,879

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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.

Facility Name & ID Number **WOODSTOCK RESIDENCE** # **0038653** Report Period Beginning: **1/1/11** Ending: **12/31/11**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	288,517	23,261	5,475	317,253		317,253		317,253			1
2	Food Purchase		197,563		197,563		197,563	(96)	197,467			2
3	Housekeeping	89,726	37,559		127,285		127,285		127,285			3
4	Laundry	65,843	11,081		76,924		76,924		76,924			4
5	Heat and Other Utilities			111,203	111,203		111,203		111,203			5
6	Maintenance	47,861	12,076	67,951	127,888		127,888		127,888			6
7	Other (specify):*											7
8	TOTAL General Services	491,947	281,540	184,629	958,116		958,116	(96)	958,020			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,526,482	133,565	4,608	1,664,655		1,664,655		1,664,655			10
10a	Therapy	94,790		353,259	448,049		448,049		448,049			10a
11	Activities	52,055	927	9,550	62,532		62,532		62,532			11
12	Social Services	37,383		2,832	40,215		40,215		40,215			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,710,710	134,492	382,249	2,227,451		2,227,451		2,227,451			16
	C. General Administration											
17	Administrative	85,349		199,000	284,349		284,349	(102,294)	182,055			17
18	Directors Fees											18
19	Professional Services			117,333	117,333		117,333	6,704	124,037			19
20	Dues, Fees, Subscriptions & Promotions			61,209	61,209		61,209	(26,011)	35,198			20
21	Clerical & General Office Expenses	187,293	9,163	86,211	282,667		282,667	38,629	321,296			21
22	Employee Benefits & Payroll Taxes			448,353	448,353		448,353		448,353			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,514	2,514		2,514	210	2,724			24
25	Other Admin. Staff Transportation			10,876	10,876		10,876	11,859	22,735			25
26	Insurance-Prop.Liab.Malpractice			102,747	102,747		102,747	1,138	103,885			26
27	Other (specify):*							17,809	17,809			27
28	TOTAL General Administration	272,642	9,163	1,028,243	1,310,048		1,310,048	(51,956)	1,258,092			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,475,299	425,195	1,595,121	4,495,615		4,495,615	(52,052)	4,443,563			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			75,096	75,096		75,096	102,877	177,973			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,120	18,120		18,120	290,131	308,251			32
33	Real Estate Taxes			57,506	57,506		57,506	2,524	60,030			33
34	Rent-Facility & Grounds			378,709	378,709		378,709	(374,937)	3,772			34
35	Rent-Equipment & Vehicles			125,651	125,651		125,651	4,788	130,439			35
36	Other (specify):*											36
37	TOTAL Ownership			655,082	655,082		655,082	25,383	680,465			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			355,281	355,281		355,281		355,281			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			418,244	418,244		418,244		418,244			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,475,299	425,195	2,668,447	5,568,941		5,568,941	(26,669)	5,542,272			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	(800)	32		10
11	Discounts, Allowances, Rebates & Refunds	(338)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(96)	2		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	(41,593)	21		18
19	Entertainment	(50)	21		19
20	Contributions	(17,207)	21		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	(22,322)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,893)	20		28
29	Other-Attach Schedule	(281)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (84,580)		\$	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)	57,911		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 57,911		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (26,669)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0038653

1/1/11

12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	IL COUNCIL LTC - COPE	\$ (2,186)	20	1
2	MISC INCOME-INTEREST	(2,357)	32	2
3	REAL ESTATE TAX ADJUSTMENT	2,524	33	3
4	ADJ S/L DEPR	1,738	30	4
5				5
6				6
7				7
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(281)		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
ESTATE OF ROBERT NATUAPSKY	100			WOODSTOCK RESIDENCE		BUILDING
				REALTY, LLC		

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	34	RENT	\$ 378,709	CCCW REALTY, LLC (pass thru to Woodstock Residence Realty, LLC)		\$ 378,709	\$	1
2	V								2
3	V	34	RENT	378,709	WOODSTOCK RESIDENCE REALTY, LLC			(378,709)	3
4	V	32	INTEREST				269,614	269,614	4
5	V	30	DEPRECIATION				95,732	95,732	5
6	V	32	MIP INSURANCE				21,384	21,384	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V	19	LEGAL FEES	18,775	LAW OFFICE OF ABRAHAM GUTNICKI		18,775		11
12	V								12
13	V								13
14	Total			\$ 776,193			\$ 784,214	\$ * 8,021	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	\$ 199,000	AA HEALTHCARE MANAGEMENT, LLC	100.00%	\$	\$ (199,000)	15
16	V	5	Utilities		AA HEALTHCARE MANAGEMENT, LLC				16
17	V	6	Repairs & Maintenance		AA HEALTHCARE MANAGEMENT, LLC				17
18	V	17	Owners Compensation		AA HEALTHCARE MANAGEMENT, LLC		96,706	96,706	18
19	V	19	Professional Fees		AA HEALTHCARE MANAGEMENT, LLC		6,704	6,704	19
20	V	20	Fees, Subscriptions		AA HEALTHCARE MANAGEMENT, LLC		390	390	20
21	V	21	Clerical Salaries		AA HEALTHCARE MANAGEMENT, LLC		95,497	95,497	21
22	V	21	Office Expenses		AA HEALTHCARE MANAGEMENT, LLC		2,320	2,320	22
23	V	24	Travel & Seminars		AA HEALTHCARE MANAGEMENT, LLC		210	210	23
24	V	25	Transportation		AA HEALTHCARE MANAGEMENT, LLC		11,859	11,859	24
25	V	26	Insurance		AA HEALTHCARE MANAGEMENT, LLC		1,138	1,138	25
26	V	27	Employee Benefits		AA HEALTHCARE MANAGEMENT, LLC		17,809	17,809	26
27	V	30	Depreciation		AA HEALTHCARE MANAGEMENT, LLC		5,407	5,407	27
28	V	32	Interest		AA HEALTHCARE MANAGEMENT, LLC		2,290	2,290	28
29	V	34	Rent		AA HEALTHCARE MANAGEMENT, LLC		3,772	3,772	29
30	V	35	Equipment Rental		AA HEALTHCARE MANAGEMENT, LLC		4,788	4,788	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 199,000			\$ 248,890	\$ * 49,890	39

* 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
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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	AARON TOPPER	MANAGER	Administrative	75.00	SEE ATTACHED	10	20.00	Mgt Fees	\$ 96,706	17-3	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	\$ 96,706		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 WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization AA HEALTHCARE MANAGEMENT
Street Address 8320 SKOKIE BLVD, SUITE 18
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 983-4860
Fax Number (847) 673-3379

	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	17	Owners Compensation	Patient Days	66,848	2	200,000		32,323	96,706	3
4	19	Professional Fees	Patient Days	66,848	2	13,865		32,323	6,704	4
5	20	Fees, Subscriptions	Patient Days	66,848	2	806		32,323	390	5
6	21	Clerical Salaries	Patient Days	66,848	2	197,500	197,500	32,323	95,497	6
7	21	Office Expenses	Patient Days	66,848	2	4,799		32,323	2,320	7
8	24	Travel & Seminars	Patient Days	66,848	2	435		32,323	210	8
9	25	Transportation	Patient Days	66,848	2	24,525		32,323	11,859	9
10	26	Insurance	Patient Days	66,848	2	2,353		32,323	1,138	10
11	27	Employee Benefits	Patient Days	66,848	2	36,831		32,323	17,809	11
12	30	Depreciation	Patient Days	66,848	2	11,183		32,323	5,407	12
13	32	Interest	Patient Days	66,848	2	4,735		32,323	2,290	13
14	34	Rent	Patient Days	66,848	2	7,800		32,323	3,772	14
15	35	Equipment Rental	Patient Days	66,848	2	9,903		32,323	4,788	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 514,735	\$ 197,500		\$ 248,890	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	CAPSTONE		X	MORTGAGE		8/1/00	\$ 4,513,800	\$			\$ 269,614	1	
2				MIP							21,384	2	
3												3	
4												4	
5												5	
	Working Capital												
6	HP BANK		X	LINE OF CREDIT							11,012	6	
7												7	
8	MISC										7,108	8	
9	TOTAL Facility Related						\$ 4,513,800	\$			\$ 309,118	9	
	B. Non-Facility Related*												
10	INTEREST INCOME OFFSET										(3,157)	10	
11												11	
12												12	
13	ALLOCATION FROM AA HC MGT										2,290	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (867)	14	
15	TOTALS (line 9+line14)						\$ 4,513,800	\$			\$ 308,251	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,384 Line # 32

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.				\$	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.)				\$	60,0302
3. Under or (over) accrual (line 2 minus line 1).				\$	60,0303
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.				\$	60,0307
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	74,027	8	
		2007	67,605	9	
		2008	62,764	10	
		2009	57,028	11	
		2010	60,030	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,252

B. General Construction Type: Exterior BRICKFrameNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?☐ 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	FACILITY	179,865		\$ 450,000	1
2					2
3	TOTALS	179,865		\$ 450,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	115		2000	1969	\$ 2,919,309	\$ 75,483	40	\$ 75,483	\$	\$ 900,357
5										
6										
7										
8										
	Improvement Type**									
9	IMPROVEMENTS			2000	206,585	10,330	20	10,330		114,485
10	IMPROVEMENTS			2001	132,870	5,598	20	5,598		58,912
11										
12	VARIOUS			1994	6,149		20	307	307	
13	VARIOUS			1995	9,053		20	453	453	
14	VARIOUS			1996	9,800		20	490	490	
15	VARIOUS			1998	6,435		20	322	322	
16	VARIOUS			2001	2,617		20	131	131	
17	VARIOUS			2002	1,702		20	85	85	
18	VARIOUS			2003	7,264		20	363	363	
19										
20	PHONES (\$2,804 MOVED TO EQUIP-2011 CAP COST DESK AUDIT)			2004			20			
21	PHONES (\$2,738 MOVED TO EQUIP-2011 CAP COST DESK AUDIT)			2004			20			
22	CONSTRUCTION DOORS			2004	2,437		20	122	122	
23	DOORS			2004	1,399		20	70	70	
24	FIRE ALARM DOOR			2005	1,511		20	76	76	
25										
26										
27	LANDSCAPING			2008	9,250		10	925	925	7,940
28	LANDSCAPING			2008	3,145		10	315	315	2,726
29	WINDOW TINTING			2009	2,597		5	519	519	2,164
30	LANDSCAPING-BOXWOOD & STONE (\$750 REMOVED-2011 CAP C			2009			15			
31	DIALYSIS PLUMBING (24582 + 22249)			2009	46,831		40	1,171	1,171	46,148
32	REPLACEMENT PART-GENERATOR			2009	3,247		10	325	325	3,058
33	A/C UNIT			2009	4,880		10	488	488	4,636
34	WATER HEATER			2009	13,687		10	1,369	1,369	13,003
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning:

1/1/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BLOCK RETAINING WALL (\$1,400 REMOVED-2011 CAP CO	2009	\$	\$	20	\$	\$	\$	37
38	REMODELING	2009	2,506		40	63	63	2,475	38
39	DIALYSIS STATION & ELEC	2009	2,394		40	60	60	2,369	39
40	DIALYSIS ROOM COSTS	2009	290		39	7	7	287	40
41	GLASS (\$424 REMOVED-2011 CAP COST DESK AUDIT)	2009			10				41
42	FLOOR FIXTURES (\$514 REMOVED-2011 CAP COST DESK A	2009			7				42
43	GLASS (\$460 REMOVED-2011 CAP COST DESK AUDIT)	2009			10				43
44	LIGHT FIXTURES & ELECTRICAL (\$1489 REMOVED-2011 C	2009			10				44
45	PLUMBING	2009	2,516		30	84	84	2,509	45
46	STAINLESS STEEL SINK & ACCESSORIES (\$1935 REMOVEI	2009			20				46
47	SIGNAGE	2009	6,254		10	625	625	5,993	47
48	REMODELING - FLOORING	2009	99,038		10	9,904	9,904	94,912	48
49	DRAPERIES & CUBICLE CURTAINS	2009	22,171		5	4,434	4,434	20,323	49
50	NURSES STATION	2009	26,145		15	1,743	1,743	25,419	50
51	WALLCOVERING	2009	64,464		5	12,893	12,893	59,092	51
52	HANDRAILS & BUMPER GUARDS	2009	32,751		15	2,183	2,183	31,841	52
53	RECESSED CANNED LIGHTING	2009	37,123		30	1,237	1,237	36,607	53
54	SHOWER/GUEST BATHROOM REMODELING	2009	39,205		39	1,005	1,005	39,205	54
55	LIGHTING	2009	427		10	43	43	424	55
56	PARKING LOT LIGHTS	2009	570		20	29	29	570	56
57	RESIDENT ROOMS-NEW LIGHTING, ETC	2009	1,930		39	49	49	1,925	57
58	REMODELING PHASE 2-SHOWER ROOMS-CONTRACT-BOI	2010	31,892		39	818	818	1,568	58
59	FIREDOORS (\$1459 REMOVED-2011 CAP COST DESK AUDIT	2010			39				59
60	REMODELING-P/Y-ADD'L PMT (\$426 REMOVED-2011 CAP C	2010			39				60
61	PLUMBING (\$1249 REMOVED-2011 CAP COST DESK AUDIT	2010			39				61
62	DINING ROOM DOOR EQUIP (\$2250 REMOVED-2011 CAP C	2010			10				62
63	PLUMBING (\$1953 REMOVED-2011 CAP COST DESK AUDIT	2010			39				63
64	FIRE DAMPERS (\$1250 REMOVED-2011 CAP COST DESK AU	2010			39				64
65	DOORS	2010	4,957		15	330	330	523	65
66	HANDICAP RAMP	2010	4,926		15	328	328	520	66
67	ROYAL CLOSET FLUSH VALVE (\$696 REMOVED-2011 CAP	2010			39				67
68	EDPM RUBBER FLAT ROOF (\$1024 REMOVED-2011 CAP CO	2010			39				68
69	FIRE DOOR IMPROVEMENTS (\$2100 REMOVED-2011 CAP C	2010			10				69
70	TOTAL (lines 4 thru 69)		\$ 3,770,327	\$ 91,411		\$ 134,777	\$ 43,366	\$ 1,479,991	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,770,327	\$ 91,411		\$ 134,777	\$ 43,366	\$ 1,479,991	1
2	DUCT WORK (\$1023 REMOVED-2011 CAP COST DESK AUDI	2010			40				2
3	DIFFUSER INSTALLATION (\$1575 REMOVED-2011 CAP COS	2010			40				3
4	FRONT DOOR EXIT DEVICE(\$605 REMOVED-2011 CAP COS	2010			10				4
5	THERAPY ROOM DIFFUSERS (\$821 REMOVED-2011 CAP CO	2010			10				5
6	RELIEF VALVE (\$1279 REMOVED-2011 CAP COST DESK AU	2010			10				6
7	RETUBING BOILER	2010	5,122		15	341	341	398	7
8	GAS VALVE (\$1002 REMOVED-2011 CAP COST DESK AUDIT	2010			10				8
9	BOILER TUBES (\$1536 REMOVED-2011 CAP COST DESK AU	2010			15				9
10	LIGHT FIXTURES (\$558 REMOVED-2011 CAP COST DESK A	2010			10				10
11	BOILER REPAIR-CONTRACT-ATLAS BOILER & WELDING	2011	2,568		10	150	150	150	11
12	PATIENT ROOM REMODELING-CONTRACT-BOB'S REMOI	2011	21,290		39	273	273	273	12
13	RANGE/OVEN (\$4,781 MOVED TO EQUIP-2011 CAP COST DI	2011							13
14	SKYLIGHT	2011	825		39	21	21	21	14
15	EXHAUST FAN MOTOR	2011	612		10	56	56	56	15
16	WATER HEATER GAS CONTROL	2011	1,074		10	63	63	63	16
17	VALVE REPLACEMENT	2011	2,295		10	115	115	115	17
18	REPAIR HOT WATER LINE IN FLOOR	2011	1,532		10	77	77	77	18
19	BRONZE BODY PUMP	2011	867		10	36	36	36	19
20	ROOM REMODELING-CONTRACT-BOB'S REMODELING, J	2011	6,129		40	51	51	51	20
21									21
22	REPAIR LEAK UNDER FLOOR	2011	3,187		40	20	20	20	22
23	ROOM REMODEL-MATERIALS-MENARDS	2011	1,127		10	28	28	28	23
24	NEW OVERLOAD CONTRACTOR	2011	944		10	8	8	8	24
25	SHED REMODEL-CONTRACT-BOB'S REMODELING	2011	20,920		39	45	45	45	25
26	SHED REMODEL-CONTRACT-BOB'S REMODELING	2011	3,518		20	15	15	15	26
27	CONCRETE PATIOS-CONTRACT-BOB'S REMODELING	2011	10,300		20	43	43	43	27
28				44,052			(44,052)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,852,637	\$ 135,463		\$ 136,119	\$ 656	\$ 1,481,390	34

**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	\$ 1,018,250	\$ 32,829	\$ 33,911	\$ 1,082		\$ 827,184	71
72	Current Year Purchases	37,903	2,536	2,536			2,536	72
73	Fully Depreciated Assets							73
74	Allocation from AA HC Mgt		5,407	5,407				74
75	TOTALS	\$ 1,056,153	\$ 40,772	\$ 41,854	\$ 1,082		\$ 829,720	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	80

E. Summary of Care-Related Assets

	1 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)	\$ 5,358,790	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 176,235	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 177,973	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,738	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,311,110	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.

		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?
16. Rental Amount for movable equipment: \$125,651Description: Med Equip \$123,997 ; Dish machine \$600; Water Softener \$140; Trailer Cooler Rental \$914
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$		\$ 171,594	\$		\$ 171,594	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			15,711			15,711	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			165,908			165,908	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				259,012		259,012	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab/Dialysis	39-02					96,269		96,269	13
14	TOTAL			\$		\$ 353,213	\$ 355,281		\$ 708,494	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (5,715)	\$	1
2	Cash-Patient Deposits	14,194		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,392,230		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,697		6
7	Other Prepaid Expenses	7,646		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	156,716		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,618,768	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	574,867		15
16	Equipment, at Historical Cost	280,709		16
17	Accumulated Depreciation (book methods)	(169,984)		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)	\$ 685,592	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,304,360	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,327,579	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,627		28
29	Short-Term Notes Payable	160,000		29
30	Accrued Salaries Payable	111,632		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	Accrued Expenses	55,385		36
37	Due Others	1,170,830		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,854,053	\$	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)	\$ 2,854,053	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (549,693)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,304,360	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (700,880)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (700,878)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	151,185	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)	\$ 151,185	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)	\$ (549,693)	24 *

* This must agree with page 17, line 47.

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,616,240	1
2	Discounts and Allowances for all Levels	538,232	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,154,472	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	368,285	6
7	Oxygen	153	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 368,438	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	175,790	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,931	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 193,721	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	800	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 800	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME--INTEREST & DISCOUNTS	2,695	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,695	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,720,126	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	958,116	31
32	Health Care	2,227,451	32
33	General Administration	1,310,048	33
	B. Capital Expense		
34	Ownership	655,082	34
	C. Ancillary Expense		
35	Special Cost Centers	355,281	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,568,941	40
41	Income before Income Taxes (line 30 minus line 40)**	151,185	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 151,185	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. TAX RETURN FILED CASH BASIS

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,896	2,080	\$ 72,777	\$ 34.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,241	13,089	372,443	28.45	3
4	Licensed Practical Nurses	14,255	15,451	371,025	24.01	4
5	CNAs & Orderlies	51,257	54,049	681,259	12.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,937	5,604	94,790	16.91	8
9	Activity Director	1,968	2,080	35,683	17.16	9
10	Activity Assistants	1,807	1,908	16,372	8.58	10
11	Social Service Workers	1,936	2,120	37,383	17.63	11
12	Dietician					12
13	Food Service Supervisor	3,617	3,929	100,572	25.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,575	21,137	187,945	8.89	15
16	Dishwashers					16
17	Maintenance Workers	3,134	3,410	47,861	14.04	17
18	Housekeepers	9,653	10,179	89,726	8.81	18
19	Laundry	6,895	7,559	65,843	8.71	19
20	Administrator	1,952	2,080	85,349	41.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,511	10,537	187,293	17.77	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	1,896	2,080	28,978	13.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,530	157,292	\$ 2,475,299 *	\$ 15.74	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	110	\$ 5,475	01-03	35
36	Medical Director		12,000	09-03	36
37	Medical Records Consultant	96	4,608	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1	46	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,832	11-03	44
45	Social Service Consultant	48	2,832	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	303	\$ 27,793		49

C. CONTRACT NURSES

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

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

** See instructions.

****See instructions.**

XX. GENERAL INFORMATION:

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

NO

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

YES

If YES, give association name and amount.

IL COUNCIL LTC \$8,772

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

YES

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

YES

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

NO

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

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

10 YRS

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

\$23,000

Line10-2

(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?

YESXNO

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

YESNOX

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

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

\$62,963

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.

\$0

Has any meal income been offset against related costs?

N/A

Indicate the amount. \$

(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?

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?

d. Have vehicle usage logs been maintained?

N/A

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

NO

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

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?

NO

Firm Name:

(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.