

		FOR BHE 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: 0042275

Facility Name: Zachary House

Address: 1100 East Avenue Streamwood 60107
Number City Zip Code

County: Cook

Telephone Number: (630) 483-0537 Fax # (630) 483-0537

HFS ID Number:

Date of Initial License for Current Owners: 12/16/96

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT

☒ PROPRIETARY

☐ GOVERNMENTAL

☐ Charitable Corp.

☐ Individual

☐ State

☐ Trust

☐ Partnership

☐ County

IRS Exemption Code

☒ "Sub-S" Corp.

Other

☐ Limited Liability Co.

☐ Trust

☐ Other

In the event there are further questions about this report, please contact:
Name: Robin Witt Telephone Number: (630) 483-0537
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 01/01/2011 to 12/31/2011
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)

(Type or Print Name) Robin Witt

(Title) Chief Financial Officer

Paid
Preparer

(Signed)

(Print Name
and Title)

(Firm Name
& Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Zachary House

0042275 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	-	-	-		8
9	SNF/PED					9
10	ICF	-	-			10
11	ICF/DD	-	-			11
12	SC	-	-			12
13	DD 16 OR LESS	<u>5,721</u>	-		<u>5,721</u>	13
14	TOTALS	5,721			5,721	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 0.979623288

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

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

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/16/96

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date 12/16/96 NO ☒

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	52,402	1,193	480	54,075	(3,376)	50,699	-	50,699			1
2	Food Purchase		23,630		23,630	-	23,630	-	23,630			2
3	Housekeeping	-	4,301	-	4,301	-	4,301	-	4,301			3
4	Laundry	-	647	-	647	-	647	-	647			4
5	Heat and Other Utilities			13,844	13,844	-	13,844	-	13,844			5
6	Maintenance	2,612	4,983	13,319	20,914	-	20,914	-	20,914			6
7	Other (specify):*	-	-	-	-	-	-	-	-			7
8	TOTAL General Services	55,014	34,754	27,643	117,411	(3,376)	114,035	-	114,035			8
	B. Health Care and Programs											
9	Medical Director				-		-		-			9
10	Nursing and Medical Records	115,665	930	5,945	122,540		122,540		122,540			10
10a	Therapy				-		-		-			10a
11	Activities		482		482		482		482			11
12	Social Services			616	616		616		616			12
13	CNA Training				-		-		-			13
14	Program Transportation				-		-		-			14
15	Other (specify):*				-		-		-			15
16	TOTAL Health Care and Programs	115,665	1,412	6,561	123,638	-	123,638	-	123,638			16
	C. General Administration											
17	Administrative	50,126	-	-	50,126	-	50,126	6,196	56,322			17
18	Directors Fees			-	-	-	-	-	-			18
19	Professional Services			6,421	6,421	-	6,421	-	6,421			19
20	Dues, Fees, Subscriptions & Promotions			199	199	-	199	-	199			20
21	Clerical & General Office Expenses	-	1,719	54,155	55,874	(319)	55,555	(25,561)	29,994			21
22	Employee Benefits & Payroll Taxes			47,344	47,344	3,376	50,720	3,063	53,783			22
23	Inservice Training & Education			-	-	-	-	-	-			23
24	Travel and Seminar			79	79	-	79	-	79			24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-			25
26	Insurance-Prop.Liab.Malpractice			3,322	3,322	-	3,322	9,807	13,129			26
27	Other (specify):*		-	-	-	-	-	-	-			27
28	TOTAL General Administration	50,126	1,719	111,520	163,365	3,057	166,422	(6,495)	159,927			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	220,805	37,885	145,724	404,414	(319)	404,095	(6,495)	397,600			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 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	
	D. Ownership											
30	Depreciation			4,616	4,616	-	4,616	12,285	16,901			30
31	Amortization of Pre-Op. & Org.			-	-	-	-	-	-			31
32	Interest			-	-	-	-	-	-			32
33	Real Estate Taxes			30,519	30,519	-	30,519	(2,594)	27,925			33
34	Rent-Facility & Grounds			156,000	156,000	-	156,000	(156,000)	-			34
35	Rent-Equipment & Vehicles			-	-	-	-	-	-			35
36	Other (specify):*			-	-	-	-	-	-			36
37	TOTAL Ownership			191,135	191,135	-	191,135	(146,309)	44,826			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-	-	-	-	-			38
39	Ancillary Service Centers	-	1,433	-	1,433	319	1,752	-	1,752			39
40	Barber and Beauty Shops	-	-	-	-	-	-	-	-			40
41	Coffee and Gift Shops	-	-	-	-	-	-	-	-			41
42	Provider Participation Fee	-	-	43,541	43,541	-	43,541	-	43,541			42
43	Other (specify):*	-	-	-	-	-	-	-	-			43
44	TOTAL Special Cost Centers	-	1,433	43,541	44,974	319	45,293	-	45,293			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	220,805	39,318	380,400	640,523	-	640,523	(152,804)	487,719			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		2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,285	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 12,285		\$	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)	(165,089)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (165,089)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (152,804)		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.		x	\$		38
39	Dental Care	x		319	21.3	39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 319		47

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
Byrn T. Witt	50%	Meadows	Rolling Meadows			
Barbara S. Witt	50%	Meadows	Rolling Meadows			

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	17	Administrative	\$ -	Meadows		\$ -	\$ -	1
2	V	17		-			-	-	2
3	V	17	Chief Financial Officer	-	Meadows		6,196	6,196	3
4	V	1	Dietary Manager	-	Meadows		-	-	4
5	V	21	Personnel, Accounting, Etc.	-	Meadows		8,611	8,611	5
6	V	21	General Office Supplies	-	Meadows		3,030	3,030	6
7	V	21	General Office Other	-	Meadows		13,198	13,198	7
8	V	22	Employee Benefits	-	Meadows		3,063	3,063	8
9	V	21	Administrative Overhead	50,400	Meadows		-	(50,400)	9
10	V	34	Facility Rent	156,000	Byrn T. Witt & Barbara S. Witt	100%	-	(156,000)	10
11	V	32	Interest	-	Byrn T. Witt & Barbara S. Witt	100%	-	-	11
12	V	26	Insurance	-	Meadows		9,807	9,807	12
13	V	33	Real Estate Tax	30,519	Byrn T. Witt & Barbara S. Witt	100%	27,925	(2,594)	13
14	Total			\$ 236,919			\$ 71,830	\$ * (165,089)	14

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

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	Robin Witt	Chief Financial Office	Administration	-0- %		2	0.05	Salary	6,196	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,196		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.

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

x

NO

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

Name of Related Organization

Meadows Sheltered Care, Inc.

Street Address

3250 South Plum Grove Road

City / State / Zip Code

Rolling Meadows, IL 60008

Phone Number

(847) 397-0055

Fax Number

(847) 397-0477

	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	17.1			-		\$	\$			1
2	21.1	Office	Direct Cost	5,600	2	103,055	103,055	468	8,611	2
3	17.1	CFO	Direct Cost	2,080	2	123,924	123,924	104	6,196	3
4				-						4
5	21.2	Office Supplies	Expenses	2,398,322	2	17,313		419,718	3,030	5
6	21.3	Office Other	Expenses	2,398,322	2	75,414		419,718	13,198	6
7	22.3	Employee Benefits	Salary	2,154,435	2	445,679		14,807	3,063	7
8	26.3	Insurance	Expenses	2,398,322	2	56,041		419,718	9,807	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					\$ 821,426	\$ 226,979		\$ 43,905	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							\$		\$			\$		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.)

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.		\$	33,113	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.)		\$	30,519	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,594)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,519	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.		\$	27,925	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	43,443	8	
		2007	44,571	9	
		2008	45,037	10	
		2009	33,113	11	
		2010	30,519	12	
Accrual based on current year assessment.		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2010 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2010 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2010.

Please complete the Real Estate Tax Statement below and include it in the 2011 cost report along with a copy of your 2010 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Zachary House COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0042275
CONTACT PERSON REGARDING THIS REPORT Robin Witt
TELEPHONE (630) 483-0537 FAX #: (630) 483-0537

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-25-301-043-0000</u>	<u>1100 East Avenue</u>	\$ <u>30,519</u>	\$ <u>30,519</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,519</u>	\$ <u>30,519</u>

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? _____ YES _____ x _____ NO

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

C. Tax Bills

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

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1996	1996	\$ 509,864	\$	39	\$ 13,073	\$ 13,073	\$ 196,095	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1997	16,650		39	427	427	6,242	9
10	Time Clock Sytem			1999	1,057		5			1,057	10
11	Floor Covering			2002	2,985		7	219	219	2,985	11
12	Wall Covering			2002	672		7	48	48	672	12
13	Bathroom cabinetry			2010	689		7	98	98	114	13
14	Driveway installation			2010	11,325		15	755	755	819	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69							-		69
70	TOTAL (lines 4 thru 69)		\$ 543,242	\$ -		\$ 14,620	\$ 14,620	\$ 207,984	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	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1 Totals from Page 12A, Carried Forward		\$ 543,242	\$ -		\$ 14,620	\$ 14,620	\$ 207,984	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34 TOTAL (lines 1 thru 33)		\$ 543,242	\$ -		\$ 14,620	\$ 14,620	\$ 207,984	34	

**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 12B, Carried Forward		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	34

**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 12C, Carried Forward		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	34

**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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	34

**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 12E, Carried Forward		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	34

**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 12F, Carried Forward		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 543,242	\$		\$ 14,620	\$ 14,620	\$ 207,984	34

**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 12G, Carried Forward		\$ 543,242	\$ 0		\$ 14,620	\$ 14,620	\$ 207,984	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
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 543,242	\$ 0		\$ 14,620	\$ 14,620	\$ 207,984	34

**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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 543,242	\$ 0		\$ 14,620	\$ 14,620	\$ 207,984	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 543,242	\$ 0		\$ 14,620	\$ 14,620	\$ 207,984	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	\$ 21,546	\$ 51	\$ 51	\$	5	\$ 21,597	71
72	Current Year Purchases	2,724	2,724	389	(2,335)	7	389	72
73	Fully Depreciated Assets	8,840					8,840	73
74								74
75	TOTALS	\$ 33,110	\$ 2,775	\$ 440	\$ (2,335)		\$ 30,826	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	Patient Transport	2006 Ford Van	2006	31,971	1,841	1,841		5	31,970	78
79										79
80	TOTALS			\$ 31,971	\$ 1,841	\$ 1,841	\$		\$ 31,970	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 753,323	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,616	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,901	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,285	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 270,780	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO

16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending

Annual Rent

12. /2012 \$
13. /2013 \$
14. /2014 \$

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

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

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	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM	IN-HOUSE PROGRAM
		IN OTHER FACILITY	IN OTHER FACILITY
		COMMUNITY COLLEGE	HOURS PER CNA
		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist	10a.3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits		4	319		4	319	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				1,433		1,433	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2								13
14	TOTAL			\$	4	\$ 319	\$ 1,433	4	\$ 1,752	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	\$ 89,220	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	223,006		3
4	Supply Inventory (priced at FIFO)	159		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	659,168		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 971,553	\$	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	11,325		15
16	Equipment, at Historical Cost	44,338		16
17	Accumulated Depreciation (book methods)	(55,534)		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)	\$ 129	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 971,682	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,896	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,896	\$	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)	\$ 13,896	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 957,786	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 971,682	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 606,898	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	159,880	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 766,778	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	191,008	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)	\$ 191,008	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)	\$ 957,786	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Zachary House

0042275

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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	\$ 815,453	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 815,453	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,078	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,078	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 831,531	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	117,411	31
32	Health Care	123,638	32
33	General Administration	163,365	33
	B. Capital Expense		
34	Ownership	191,135	34
	C. Ancillary Expense		
35	Special Cost Centers	1,433	35
36	Provider Participation Fee	43,541	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 640,523	40
41	Income before Income Taxes (line 30 minus line 40)**	191,008	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 191,008	43

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,283	4,485	52,401	11.68	15
16	Dishwashers					16
17	Maintenance Workers	170	170	2,612	15.37	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,823	2,080	50,126	24.10	20
21	Assistant Administrator					21
22	Other Administrative	104	104	6,196	59.58	22
23	Office Manager					23
24	Clerical	468	468	8,611	18.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	583	613	9,579	15.63	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	8,120	8,684	106,086	12.22	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	15,551	16,604	\$ 235,612 *	\$ 14.19	34

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

** See instructions.

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	12	\$ 480	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	191	4,856	10.3	38
39	Pharmacist Consultant	11	616	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant				44
45	Social Service Consultant			12.3	45
46	Other(specify) Psychologist			12.3	46
47					47
48				12.3	48
49	TOTAL (lines 35 - 48)	214	\$ 5,952		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

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			
Robin Witt	CFO		6,196	Workers' Compensation Insurance	\$	15,263	IDPH License Fee	\$			
Donita Lyle-Link	Administrator		50,126	Unemployment Compensation Insurance		1,339	Advertising: Employee Recruitment				
				FICA Taxes		16,283	Health Care Worker Background Check				
				Employee Health Insurance		13,484	(Indicate # of checks performed)				
				Employee Meals		3,376	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*							
				Staff Appreciation			Secretary of State	199			
				Employee Life/Disability		83					
				Dental Insurance		892					
				Allocation of Employee Benefits		3,063					
				Employee Physicals							
							Less: Public Relations Expense	()			
							Non-allowable advertising	()			
							Yellow page advertising	()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$	56,322	TOTAL (agree to Sch. V, line 20, col. 8)		\$	199	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description				Description			Description				
Amount				Line #			Amount				
\$				\$			\$				
							Out-of-State Travel			\$	
							In-State Travel				
							Seminar Expense			79	
							Entertainment Expense			()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			(agree to Sch. V, line 24, col. 8)			\$	79
C. Professional Services											
Vendor/Payee	Type		Amount								
			\$								
Robert Rein CPA			2,400								
	Reclass										
ADP	Payroll		4,021								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)											

* Attach copy of IMRF notifications

**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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

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

No

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

No
-

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

No

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

No

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

Yes
7

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

\$ - Line 10.2

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

Yes

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

No

(9) Are you presently operating under a sublease agreement?

YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 43,541

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

No
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

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

No

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

\$ 3,376
No

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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

100%

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

No

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

No

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

Yes

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

Yes