

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0042820</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Coulterville Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/12</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>13138 State Rte 13</u> <u>Coulterville</u> <u>62237</u>																									
Number City Zip Code																									
County: <u>Randolph</u>																									
Telephone Number: <u>(618) 758-2256</u> Fax # <u>(618) 758-3407</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) <u>Andrea McFadden</u></td></tr><tr><td>(Title) <u>Executive Director</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>630-361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Andrea McFadden</u>	(Title) <u>Executive Director</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>630-361-2868</u> 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												
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Date of Initial License for Current Owners: <u>11/12/1999</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:																									
Name: <u>Larry Templin</u> Telephone Number: <u>630-361-2868</u>																									
Email Address: _____																									

Facility Name & ID Number Coulterville Care Center# 0042820 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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 bedsN/A

	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>75</u>	Skilled (SNF)	<u>75</u>	<u>27,450</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>75</u>	TOTALS	<u>75</u>	<u>27,450</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>11,792</u>	<u>8,466</u>	<u>4,576</u>	<u>24,834</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>11,792</u>	<u>8,466</u>	<u>4,576</u>	<u>24,834</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.47%

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

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒Non-allowable costs have been
eliminated in Schedule V, Column 7

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 11/12/1999

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

YES ☒Date 11/12/1999NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 75 and days of care provided 4,576Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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	183,250	20,339	5,498	209,087		209,087		209,087			1
2	Food Purchase		192,120		192,120		192,120	(587)	191,533			2
3	Housekeeping	74,389	16,055		90,444		90,444		90,444			3
4	Laundry	65,467	12,019		77,486		77,486		77,486			4
5	Heat and Other Utilities			107,631	107,631		107,631		107,631			5
6	Maintenance	28,334	2,560	57,070	87,964		87,964		87,964			6
7	Other (specify):* Waste Removal			7,347	7,347		7,347		7,347			7
8	TOTAL General Services	351,440	243,093	177,546	772,079		772,079	(587)	771,492			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,137,607	131,188	42,285	1,311,080		1,311,080		1,311,080			10
10a	Therapy			676,973	676,973		676,973		676,973			10a
11	Activities	40,384	6,800	10,240	57,424		57,424		57,424			11
12	Social Services	28,232		1,794	30,026		30,026		30,026			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,206,223	137,988	737,292	2,081,503		2,081,503		2,081,503			16
	C. General Administration											
17	Administrative	78,110		131,250	209,360		209,360		209,360			17
18	Directors Fees											18
19	Professional Services			83,055	83,055		83,055	(6,238)	76,817			19
20	Dues, Fees, Subscriptions & Promotions			9,577	9,577		9,577	(50)	9,527			20
21	Clerical & General Office Expenses	115,213	17,471	20,321	153,005		153,005		153,005			21
22	Employee Benefits & Payroll Taxes			419,791	419,791		419,791		419,791			22
23	Inservice Training & Education			3,866	3,866		3,866		3,866			23
24	Travel and Seminar			10,182	10,182		10,182		10,182			24
25	Other Admin. Staff Transportation			3,470	3,470		3,470		3,470			25
26	Insurance-Prop.Liab.Malpractice			89,868	89,868		89,868	(3,542)	86,326			26
27	Other (specify):*											27
28	TOTAL General Administration	193,323	17,471	771,380	982,174		982,174	(9,830)	972,344			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,750,986	398,552	1,686,218	3,835,756		3,835,756	(10,417)	3,825,339			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			23,856	23,856		23,856	141,376	165,232			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,027	10,027		10,027	(10,027)				32
33	Real Estate Taxes			70,745	70,745		70,745		70,745			33
34	Rent-Facility & Grounds			576,134	576,134		576,134		576,134			34
35	Rent-Equipment & Vehicles			9,177	9,177		9,177		9,177			35
36	Other (specify):*											36
37	TOTAL Ownership			689,939	689,939		689,939	131,349	821,288			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,690	4,690		4,690		4,690			38
39	Ancillary Service Centers		122,294		122,294		122,294		122,294			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			251,634	251,634		251,634		251,634			42
43	Other (specify):* Non-allowable Costs			327,640	327,640		327,640	(327,640)				43
44	TOTAL Special Cost Centers		122,294	583,964	706,258		706,258	(327,640)	378,618			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,750,986	520,846	2,960,121	5,231,953		5,231,953	(206,708)	5,025,245			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(587)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,746)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	141,376	30		9
10	Interest and Other Investment Income	(10,027)	32		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	(50)	20		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	(278,883)	43		24
25	Fund Raising, Advertising and Promotional	(18,560)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(33,231)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (206,708)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (206,708)		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						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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Coulterville Care Center

	ID#	0042820
Report Period Beginning:		1/1/2012
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Laboratory	\$ (15,153)	43	1
2	Disallow X-Ray	(8,298)	43	2
3	Offset Dividend from Insurance Company	(3,542)	26	3
4	Non-Allowable Legal Fees	(6,238)	19	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
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33				33
34				34
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(33,231)		49

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
Board of Directors:		None		None		
Harold Joines-President	0					
Kenneth Curry-Secretary/Treasurer	0					
William Jarrett-Board Member	0					
William Mueller-Board Member	0					

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

☐ YES ☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2012 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related Long-Term														
1							\$		\$			\$	1		
2													2		
3													3		
4													4		
5													5		
	Working Capital														
6	Southern Healthcare, LLC		X	Working Capital	Interest Only	01/01/12		200,000	200,000	Demand		0.0500	10,027	6	
7													7		
8													8		
9	TOTAL Facility Related						\$	200,000	\$	200,000			\$	10,027	9
	B. Non-Facility Related*														
10														10	
11								Interest income offset					(10,027)	11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$	(10,027)	14
15	TOTALS (line 9+line14)						\$	200,000	\$	200,000			\$		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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 2011 report.		\$	70,745	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.)		2011	\$	72,646	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,901	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	68,844	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.		\$	70,745	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	61,408	8	
		2008	66,109	9	
		2009	70,745	10	
		2010	72,499	11	
		2011	72,646	12	
Accrual based on prior year tax bill.					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Coulterville Care Center

COUNTY
Randolph

FACILITY IDPH LICENSE NUMBER
0042820

CONTACT PERSON REGARDING THIS REPORT
Andrea McFadden

TELEPHONE
(618) 758-2256
FAX #:
(618) 758-3407

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	16-043-056-50	NURSING FACILITY	\$ 72,646.14	\$ 72,646.14
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 72,646.14	\$ 72,646.14

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,606 B. General Construction Type: Exterior Brick Frame Steel Number of Stories one

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).

N/A

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning:

1/1/2012

Ending:

12/31/12

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75		1999	1999	\$ 3,409,916	\$	40	\$ 85,248	\$ 85,248	\$ 1,066,063	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alarm System			1999	32,465		10			32,465	9
10	Concrete Floor-Storage Building			2005	2,450		15	163	163	1,116	10
11	Removal of Dining Room Wall and Minor Repainting			2007	7,960		5	1,592	1,592	3,670	11
12	Parking Lot			2007	9,587		15	639	639	7,989	12
13	Front Door of Building			2008	5,556		10	556	556	2,454	13
14	Outdoor Keypad			2008	1,083		5	217	217	921	14
15	Smoker's Pavillion			2008	2,011		5	402	402	1,474	15
16	Cabling for Voice & Internet			2009	9,072		5	1,814	1,814	6,047	16
17	Exterior Lighting			2009	1,060		5	212	212	725	17
18	New Slide Door Package			2009	7,044		10	704	704	1,937	18
19	Hall Shower Room Flooring			2010	9,367		10	937	937	1,874	19
20	Hall Receiving Door			2010	4,345		10	435	435	833	20
21	Hall Shower Room Flooring			2010	3,122		10	312	312	598	21
22	Hall Shower Room Flooring			2010	5,050		10	505	505	968	22
23	Patio Fence			2010	6,090		10	609	609	1,066	23
24	Patio Fence Improvements			2011	1,200		10	120	120	150	24
25	Parking Lot Repair and Seal			2011	4,643	928	5	929	1	1,393	25
26	Door hinges (qty 3)			2011	3,840	768	5	768		1,024	26
27	Kitchen Make-Up Air Unit			2011	24,618	1,641	15	1,641		2,188	27
28	Kitchen Make-Up Air Unit add'l			2011	247	16	15	16		21	28
29	Door hinges (qty 12)			2011	868	174	5	174		217	29
30	Door hinges (qty 3)			2011	3,840	768	5	768		960	30
31	Mixer Valves (North Hall)			2011	1,823	122	15	122		152	31
32	Fence Posts			2011	540	36	15	36		42	32
33	Kitchen Make-Up Air Unit add'l			2011	344	23	15	23		27	33
34	Door hinges (qty 3)			2011	3,840	768	5	768		896	34
35	Seal Kits (qty 15)			2011	3,840	768	5	768		896	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

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning:

1/1/2012

Ending:

12/31/12

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	Combination Locks	2011	277	55	5	55	\$	\$ 64	37
38									38
39	Kitchen Remodel:								39
40	Duct Heater	2012	2,057	377	15	69	(308)	69	40
41	Re-route refrigeration piping	2012	10,293	1,201	15	343	(858)	343	41
42	Motor, wheel, and bracket	2012	1,575	184	15	53	(131)	53	42
43	Kitchen unit switch and valves	2012	1,627	190	15	54	(136)	54	43
44	Kitchen compressor and line filter dryer	2012	4,217	422	15	141	(281)	141	44
45	Kitchen Walk-in cooling unit switch	2012	1,532	153	15	51	(102)	51	45
46	New Fire Sprinkler line	2012	1,361	91	15	45	(46)	45	46
47	Commercial Disposer	2012	1,412	118	15	47	(71)	47	47
48									48
49	Resident Room Remodel:								49
50	Vanities	2012	4,377	633	15	146	(487)	146	50
51	Overhead Bed lighting	2012	3,203	433	15	107	(326)	107	51
52	Mini blinds for Room 208	2012	322	5	15	11	6	11	52
53	PTAC Units	2012	6,805	1,356	15	227	(1,129)	227	53
54									54
55	Secure Wireless Solution Hardware & Labor	2012	6,088	101	15	203	102	203	55
56	Door hinges (qty 3)	2012	3,728	746	15	124	(622)	124	56
57	Parking curbs	2012	622	83	15	21	(62)	21	57
58	Window A/C (Employee lounge)	2012	472	55	15	16	(39)	16	58
59	5-ton compressor (common area)	2012	2,947	344	15	98	(246)	98	59
60	Water Heater	2012	6,945	579	15	232	(347)	232	60
61	Storage Building	2012	4,956	413	15	165	(248)	165	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,630,637	\$ 13,551		\$ 102,686	\$ 89,135	\$ 1,140,383	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$534,801	\$4,132	\$56,373	\$52,241	3	\$356,355	71
72	Current Year Purchases	39,725	6,173	6,173		3	6,173	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$574,526	\$10,305	\$62,546	\$52,241		\$362,528	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)	\$4,205,163	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$23,856	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$165,232	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$141,376	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,502,911	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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:Southern Healthcare, LLC
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:	1999	75	06/15/2011	\$ 382,338	10		3
4	Additions							4
5								5
6								6
7	TOTAL		75		\$ 382,338			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 lease20 years.
9. Option to Buy:☐ YES☒ NOTerms: N/A*

10. Effective dates of current rental agreement:

Beginning06/15/2011
Ending06/14/2031

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

	Fiscal Year Ending	Annual Rent
12.	6/2013	\$ 420,000
13.	6/2014	\$ 420,000
14.	6/2015	\$ 420,000

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:\$ 9,177Description:Copier - \$7,979, Medical Equipment - \$728, Dishwasher - \$470
(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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

* 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

It is the policy of this facility to only hire certified nurses aides.
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

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	\$	5,255	\$ 268,022	\$	5,255	\$ 268,022	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,669	106,008		1,669	106,008	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,059	302,943		6,059	302,943	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				122,294		122,294	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,983	\$ 676,973	\$ 122,294	12,983	\$ 799,267	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 76,449	\$ 76,449	1
2	Cash-Patient Deposits	14,044	14,044	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 463,723)	913,392	913,392	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,071	45,071	6
7	Other Prepaid Expenses	61,604	61,604	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Lease Deposit	300,000	300,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,410,560	\$ 1,410,560	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,057,311	3,057,311	14
15	Leasehold Improvements, at Historical Cost	85,158	573,326	15
16	Equipment, at Historical Cost	75,577	574,526	16
17	Accumulated Depreciation (book methods)	(333,878)	(1,502,911)	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)	\$ 2,884,168	\$ 2,702,252	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,294,728	\$ 4,112,812	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 508,276	\$ 508,276	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,809	12,809	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,262	69,262	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,817	3,817	31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,844	68,844	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Management Fees Payable	11,283	11,283	36
37	Deferred Gain/Loss on Sale	22,235	22,235	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 696,526	\$ 696,526	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	200,000	200,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Capital Lease Obligation	2,996,520	2,996,520	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,196,520	\$ 3,196,520	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,893,046	\$ 3,893,046	46
47	TOTAL EQUITY(page 18, line 24)	\$ 401,682	\$ 219,766	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,294,728	\$ 4,112,812	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 725,342	1
2	Restatements (describe):		2
3			3
4	Rounding	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 725,343	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(323,661)	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)	\$ (323,661)	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)	\$ 401,682	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Coulterville Care Center# 0042820Report Period Beginning: 1/1/2012Ending: 12/31/12

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	2	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,518,399	1
2	Discounts and Allowances for all Levels	(290,522)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,227,877	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	526,115	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 526,115	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	483	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	135,473	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 135,956	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,493	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,493	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income (Offset), Deferred Gain/Loss	4,851	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,851	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,908,292	30

	1	2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	772,079	31
32	Health Care	2,081,503	32
33	General Administration	982,174	33
	B. Capital Expense		
34	Ownership	689,939	34
	C. Ancillary Expense		
35	Special Cost Centers	454,624	35
36	Provider Participation Fee	251,634	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,231,953	40
41	Income before Income Taxes (line 30 minus line 40)**	(323,661)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (323,661)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,078,906	44
45	Private Pay - Net Inpatient Revenue	1,304,501	45
46	Medicare - Net Inpatient Revenue	1,844,470	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,227,877	49

* 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	4,080	4,368	\$ 130,233	\$ 29.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,233	4,393	92,781	21.12	3
4	Licensed Practical Nurses	16,749	17,417	296,433	17.02	4
5	CNAs & Orderlies	48,459	50,768	590,071	11.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,216	3,314	40,384	12.19	10
11	Social Service Workers	1,864	2,096	28,232	13.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,592	17,361	183,250	10.56	15
16	Dishwashers					16
17	Maintenance Workers	2,094	2,171	28,334	13.05	17
18	Housekeepers	8,066	8,494	74,389	8.76	18
19	Laundry	6,893	7,321	65,467	8.94	19
20	Administrator	2,080	2,080	78,110	37.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,595	8,276	115,213	13.92	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	2,168	2,302	28,089	12.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,089	130,361	\$ 1,750,986 *	\$ 13.43	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	Monthly	\$ 5,498	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	12	926	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,499	L11, C3	44
45	Social Service Consultant	Monthly	1,794	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	12	\$ 16,717		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	N/A			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.

STATE OF ILLINOIS

Facility Name & ID Number

Coulterville Care Center

0042820

Report Period Beginning:

1/1/2012

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Ending:

12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Description		Amount		Description		Amount	
Andrea McFadden		Exec Director	0	Workers' Compensation Insurance		\$ 89,555		IDPH License Fee		\$	
				Unemployment Compensation Insurance		23,316		Advertising: Employee Recruitment		4,807	
				FICA Taxes		130,974		Health Care Worker Background Check		1,584	
				Employee Health Insurance		151,820		(Indicate # of checks performed 49)			
				Employee Meals				Patient Background Checks		50	
				Illinois Municipal Retirement Fund (IMRF)*				LSN		1,497	
				Employee Physicals / Screenings		9,311		Miscellaneous License/Fees		851	
				Disability Insurance		3,074		Misc. Dues & Subscriptions		338	
				Employee Parties and Gifts		9,871					
				Flu Vaccines		1,220					
				Other Benefits		650					
								Less: Public Relations Expense		(50)	
								Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)								TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,527	
(List each licensed administrator separately.)			\$ 78,110	TOTAL (agree to Schedule V, line 22, col.8)		\$ 419,791					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
Management Fees - St. Andrews Management Services			\$ 110,000				\$	Out-of-State Travel		\$	
Management Fees - Howell Business Solutions			21,250								
				N/A				In-State Travel		3,813	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 131,250								
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount								
ADP		Payroll Processing	\$ 9,327								
Bonnett, Fairbourn,Friedman & Bal		Legal	1,088								
Armstrong Teasdale LLP		Legal	2,535								
The Lowenbaum Partnership, LLC		Legal	266								
Farris Law Office		Collections-Disallowed (col 7)	6,238								
BKD, LLP		Accounting	25,452								
St. Andrews Management Services		Computer Services	22,000								
Answers on Demand		Computer Services	9,519					Seminar Expense		6,369	
Accu-Med		Computer Services	450								
Ivans		Computer Services	4,647								
CTS Technology Solutions		Computer Services	1,218								
Misc. Vendors below \$200 each		Computer Services	315					Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 83,055					TOTAL		\$ 10,182	

* 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	N/A												
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?

Yes

If YES, give association name and amount.

1,497 LSN
- (3)

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

No

If YES, have these costs been properly adjusted out of the cost report?
- (4)

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

No

If YES, what is the capacity?

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?

3 years
- (6)

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

\$

22,310

Line

10
- (7)

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

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

Yes

If YES, give effective date of lease.

6/15/11
- (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.

\$

251,634

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?

Yes

Indicate the amount.

\$

587
- (16)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

N/A

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

N/A

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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

No

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

\$

N/A
- (17)

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

No

Firm Name:

N/A
- (18)

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

Yes
- (19)

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

N/A

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