

		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: 8000192 Facility Name: Hammond-Henry District Hospital Address: 600 North College Avenue Geneseo 61254 County: Henry Telephone Number: (309) 944-6431 Fax #: (309) 944-6917 HFS ID Number: Date of Initial License for Current Owners: January 1, 2002 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other XGOVERNMENTAL State County XOtherHospital District
--

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Bradley Soldberg

(Title) Chief Executive Officer

(Signed)

(Date)

Paid Preparer

(Print Name and Title) Dan Linhart Manager

(Firm Name & Address) McGladrey LLP 201 N. Harrison Street, Suite 300, Davenport, IA 52801

(Telephone) (563) 888-4404 Fax #: (563) 324-6939

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

In the event there are further questions about this report, please contact:
Name: Jodie Criswell, VP of Fiscal Services Telephone Number: (309) 944-9103
Email Address:

Facility Name & ID Number Hammond-Henry District Hospital# 8000192 Report Period Beginning: 06/01/11 Ending: 05/31/12

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 beds July 2011

	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>25</u>	Skilled (SNF)	<u>37</u>	<u>13,182</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	25	TOTALS	37	13,182	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>1,077</u>	<u>9,696</u>	<u>2,276</u>	<u>13,049</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,077	9,696	2,276	13,049	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.99%

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)

0F. 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 ☒Note : 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 01/01/1986

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

YES ☐

Date _____

NO ☒

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

YES ☒NO ☐If YES, enter number
of beds certified 37 and days of care provided 1,197Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 5/31/12 Fiscal Year: 5/31/12

* 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	157,542		145,817	303,359		303,359		303,359			1
2	Food Purchase											2
3	Housekeeping	112,137		36,594	148,731		148,731		148,731			3
4	Laundry	13,399		52,319	65,718		65,718		65,718			4
5	Heat and Other Utilities											5
6	Maintenance	45,217		299,085	344,302		344,302		344,302			6
7	Other (specify):*											7
8	TOTAL General Services	328,295		533,815	862,110		862,110		862,110			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	788,567	71,284	31,141	890,992		890,992		890,992			10
10a	Therapy											10a
11	Activities	46,226	3,211	5,059	54,496		54,496		54,496			11
12	Social Services	140,208		1,657	141,865		141,865		141,865			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	975,001	74,495	37,857	1,087,353		1,087,353		1,087,353			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	83,476		118,670	202,146		202,146		202,146			21
22	Employee Benefits & Payroll Taxes			365,728	365,728		365,728		365,728			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*	27,196		321	27,517		27,517		27,517			27
28	TOTAL General Administration	110,672		484,719	595,391		595,391		595,391			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,968	74,495	1,056,391	2,544,854		2,544,854		2,544,854			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			292,012	292,012		292,012	(72,655)	219,357			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			292,012	292,012		292,012	(72,655)	219,357			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,413,968	74,495	1,348,403	2,836,866		2,836,866	(72,655)	2,764,211			45

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

		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				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	(72,655)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (72,655)		\$	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	2	
		Amount	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))	\$ (72,655)		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	2	3	4	
		Yes	No	Amount	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

STATE OF ILLINOIS
Hammond-Henry District Hospital

Report Period Beginning: ID# 8000192
Ending: 06/01/11
05/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		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

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											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 Hammond-Henry District Hospital # 8000192 Report Period Beginning: 06/01/11 Ending: 05/31/12

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													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. \$ N/A 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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011	\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.		Mgmt. Alloc.		
(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.		Allocated from Management Co.		
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2007 8	FOR BHF USE ONLY	
		2008 9		
		2009 10	13 FROM R. E. TAX STATEMENT FOR 2011 \$	13
		2010 11	14 PLUS APPEAL COST FROM LINE 5 \$	14
		2011 12	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 _____ COUNTY _____
FACILITY IDPH LICENSE NUMBER _____
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE _____ FAX #: _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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: 18,895

B. General Construction Type: Exterior Brick Frame Steel

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	133,009	1954	\$ 91,835	1
2	Building	9,000	2007	31,500	2
3	TOTALS	142,009		\$ 123,335	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	37			2011	\$ 3,423,198	\$		\$ 155,584	\$ 155,584	\$ 155,584
5										
6										
7										
8										
	Improvement Type**									
9	CUSTOM DRAPERIES - CHICAGO STREET DECORATING			2011	37,250		5	7,450	7,450	7,450
10	TUB - ARJOHUNTLEIGH			2011	12,923		7	1,846	1,846	1,846
11	IN FLOOR SCALE - DIRECT SUPPLY			2011	6,895		10	690	690	690
12										
13										
14										
15	Allocated Depreciation					292,012			(292,012)	
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

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)		\$3,480,267	\$292,012		\$165,570	\$(126,442)	\$165,570	70

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

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	\$78,399	\$	\$3,611	\$3,611		\$66,905	71
72	Current Year Purchases	209,578		50,176	50,176		17,097	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$287,977	\$	\$53,787	\$53,787		\$84,002	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	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)	\$ 3,891,579	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 292,012	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 219,357	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (72,655)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 249,572	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,509,377	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,001,641		3
4	Supply Inventory (priced at)	832,061		4
5	Short-Term Investments	1,011,295		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	225,867		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Property Taxes & Other AR</u>	1,435,117		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,015,358	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,660,156		12
13	Land	1,210,071		13
14	Buildings, at Historical Cost	45,474,380		14
15	Leasehold Improvements, at Historical Cost	(12,932,604)		15
16	Equipment, at Historical Cost	11,543,496		16
17	Accumulated Depreciation (book methods)	(6,300,723)		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): <u>Deferred Cost & Other Rec.</u>	1,100,040		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 49,754,816	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 61,770,174	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,274,432	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,430,956		29
30	Accrued Salaries Payable	1,320,756		30
31	Accrued Taxes Payable (excluding real estate taxes)	304,560		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	41,295		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>3rd Party Settlement</u>	1,153,172		36
37	<u>Deferred Rev.</u>	305,420		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,830,591	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	27,242,468		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)	\$ 27,242,468	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 33,073,059	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,697,115	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 61,770,174	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 27,685,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 27,685,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(971,930)	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) Operating Misc Rev	1,103,446	15
16	Other (describe) Non-Operating Misc Rev	879,934	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,011,450	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)	\$ 28,697,115	24 *

* This must agree with page 17, line 47.

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

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 2,214,680	1	
2Discounts and Allowances for all Levels	()	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,214,680	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy		6	
7Oxygen		7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care		13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs		17	
18Sale of Supplies to Non-Patients		18	
19Laboratory		19	
20Radiology and X-Ray		20	
21Other Medical Services		21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***		25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28aHospital Net Revenue	27,854,846	28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,854,846	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 30,069,526	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	862,110	31	
32Health Care	1,087,353	32	
33General Administration	595,391	33	
B. Capital Expense			
34Ownership	292,012	34	
C. Ancillary Expense			
35Special Cost Centers		35	
36Provider Participation Fee		36	
D. Other Expenses (specify):			
37Hospital Expenses	28,204,590	37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 31,041,456	40	
41Income before Income Taxes (line 30 minus line 40)**	(971,930)	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (971,930)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$	44	
45Private Pay - Net Inpatient Revenue		45	
46Medicare - Net Inpatient Revenue		46	
47Other-(specify)		47	
48Other-(specify)		48	
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49	

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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	7,706	8,531	249,227	29.21	3
4	Licensed Practical Nurses	8,064	8,603	158,087	18.38	4
5	CNAs & Orderlies	25,367	28,908	336,361	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,477	4,008	47,618	11.88	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,952	2,291	43,499	18.99	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	46,566	52,341	\$ 834,792 *	\$ 15.95	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

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

** See instructions.

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?

No

If YES, give association name and amount.

No

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

No

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

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

No

If YES, what is the capacity?

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

Yes

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

N/A

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

0

 Line

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

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

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

X

 NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO

X

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

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

0

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. \$

See Medicare CR

(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. \$

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

0

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?

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. \$

0

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

Yes

Firm Name:

McGladrey LLP

(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.

HFS 3745 (N-4-99)

IL478-2471

RECONCILIATION REPORT

Hammond-Henry Distric

04:02 PM

6/13/2013

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-72,655	equal to	-72,655	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	219,357	equal to	219,357	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	#VALUE!	#VALUE!	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies		equal to	0	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	862,110	equal to	862,110	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,087,353	equal to	1,087,353	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	595,391	equal to	595,391	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	292,012	equal to	292,012	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	0	equal to	0	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	0	equal to	0	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	787,174	equal to	788,567	-1,393	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	47,618	equal to	46,226	1,392	FAILED	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to	140,208	-140,208	FAILED	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	0	equal to	157,542	-157,542	FAILED	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	0	equal to	45,217	-45,217	FAILED	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to	112,137	-112,137	FAILED	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to	13,399	-13,399	FAILED	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	0	equal to	0	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to	83,476	-83,476	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	834,792	equal to	1,413,968	-579,176	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	145,817	-145,817	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to	0	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	0	< or = to	31,141	-31,141	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	5,059	-5,059	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	1,657	-1,657	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.		equal to	0	#VALUE!	#VALUE!	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to	0	#VALUE!	#VALUE!	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.		equal to	0	#VALUE!	#VALUE!	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	365,579	equal to	365,728	-149	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..		equal to	0	#VALUE!	#VALUE!	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav		equal to	0	#VALUE!	#VALUE!	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	0	equal to	0	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,197	equal to	2,276	-1,079	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	0	equal to	0	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	123,335	equal to	0	123,335	FAILED	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,480,267	equal to	0	3,480,267	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	287,977	equal to	0	287,977	FAILED	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	249,572	equal to	0	249,572	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	28,697,115	equal to	28,697,115	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-971,930	equal to	-971,930	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	61,770,174	equal to	61,770,174	0	FAILED	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 11 divided by 2 =
Beginning Day + Ending Day = 32 divided by 60.8 =
Beginning Year + Ending Year = 223 multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost
(from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is
equal to or above 93 percent, divide your total updated
support costs (Step II, C, 3, above) by the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent
of the licensed bed days (Cost Report, Page 2, Schedule III-A,
Column 4, Line 7). Then subtract the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5,
Line 14) from the result and calculate one-third of the
difference. Then add the one-third difference to the total
patient days to obtain your adjusted occupancy. Next
divide your total updated Support Costs (Step II, C, 3 above)
by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

- A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.
- B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

- C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is

35th Percentile is

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

\$328,295
\$1,413,968
23.2180%
\$365,728

\$84,915
\$862,110
\$947,025

\$110,672
\$1,413,968
7.8271%

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$365,728
<u>\$28,626</u>
\$595,391
\$365,728
<u>\$258,289</u>

5.5
0.526315789
1338
1344.026316
<u>907.00</u>
437

1
1

\$947,025
<u>1</u>

\$947,025

\$258,289
<u>1</u>
\$258,289
<u>\$1,205,314</u>

\$92.37

\$1,205,314
<u>13,049</u>
<u>\$92.37</u>

13,182
<u>0.93</u>
12,259
<u>13,049</u>
-790
-263
<u>13,049</u>
<u>12,786</u>

\$1,205,314
12786
\$94.27

#N/A
\$92.37
#N/A
0.5
#N/A
\$92.37
#N/A

#N/A
\$92.37
#N/A

0.5
#N/A
#N/A
#N/A
\$92.37
#N/A
#N/A
#N/A
#N/A

DD 16 Facilities)
centiles by HSA

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655

Capital Rate Data

Change print Orientation!

Facility Name:

=PG1!E14

HSA No.:

IF RENTED, have facilities been continuously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978?

Cost Report Pd:

Begin

End

1989 Property Tax COST:

1991 Property Tax RATE:

FY 1991 Capital Rate:

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED

TO THE COST REPORT!!!!

6/13/2013

04:02:06 PM

COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

ID:

=pg1!j12

Own or Rent? (O or R)

O

Own or Rent Beginning:

O

N

Licensed Beds:

37

Total Patient Days

13,049

Licensed Bed Days:

13,182

% Occupied

98.99%

Capital Days

13,049

(Actual dollar amount 1989 taxes)

(Inflated dollar amount divided by 1991 capital days)

(From form 787)

2011 rate #N/A

2010 rate

Variance #N/A

CAPITAL CALCULATIONS

=PG1!E14

Estimate of revised capital rate due to improvements 2000-200?

A. Determine the base year for your building from Work Table A

B. Determine the Building Specific historical cost per bed:

1. Work Table A, Line 24, Column (B)
2. Total licensed beds from cost report Page 2, Line 7, column 3
3. Line 1 divided by Line 2
4. Regional construction inflator from Table 2
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even \$)

C. Obtain the Uniform Building Value from Table 1

D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5

1. Building specific historical cost from Line B5
2. Uniform building value from Line C
3. Add Lines 1 and 2
4. Divide by 2 to obtain average
5. Enter 120% of line C
6. The blended value is the lesser of Line 4 or Line 5

E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment

F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)

G. Add \$2.50 to Line F for equipment, rent, vehicle and working capital.

H. Add Lines F & G to obtain the preliminary capital rate

I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)

1. Enter the FY 91 capital rate
2. Subtract the FY 91 property tax rate
3. FY 91 rate without tax
4. Multiply Line I3 by 115%
5. Implementation capital rate

J. Property Tax

Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)
2. Divided by: Capital Days (see below)

- 3. Equals: Per Diem Cost
- 4. Times: Property Tax Inflator (Table 3)
- 5. Equals: Updated Property Tax Cost

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

- 1. Total Patient Days
- 2. Total Licensed Bed Days * .93
- 3. Capital Days (higher of Line 1 or Line 2)

K. Total Capital Rate for FY 94

- 1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I
- 2. Add Property Tax from Line J5
- 3. Total capital rate (add Lines 1 & 2)

Adjust above for rate cut & COLAs (L74) x .941 x 1.03 x 1.03

Capital rate as of ?

Potential Rate Increase

Estimate of annual Medicaid days

Estimated increase in annual Medicaid revenue

=PG1!E14

Estimate of revised capital rate due to improvements 2000-200?

	\$0.00	51	51	0	0	0	12A	147	0	0	0	12D
#N/A		52	52	0	0	0	12A	148	0	0	0	12D
#N/A		53	53	0	0	0	12A	149	0	0	0	12D
		54	54	0	0	0	12A	150	0	0	0	12D
		55	55	0	0	0	12A	151	0	0	0	12D
		56	56	0	0	0	12A	152	0	0	0	12D
		57	57	0	0	0	12A	153	0	0	0	12D
		58	58	0	0	0	12A	154	0	0	0	12D
		59	59	0	0	0	12A	155	0	0	0	12D
13,049		60	60	0	0	0	12A	156	0	0	0	12D
12259		61	61	0	0	0	12A	157	0	0	0	12D
13,049		62	62	0	0	0	12A	158	0	0	0	12D
		63	63	0	0	0	12A	159	0	0	0	12D
		64	64	0	0	0	12A	160	0	0	0	12D
		65	65	0	0	0	12A	161	0	0	0	12D
#N/A		66	66	0	0	0	12A	162	0	0	0	12D
		67	67	0	0	0	12B					
#N/A		68	68	0	0	0	12B					
#N/A		69	69	0	0	0	12B					
#N/A		70	70	0	0	0	12B					
		71	71	0	0	0	12B					
		72	72	0	0	0	12B					
#N/A		73	73	0	0	0	12B					
		74	74	0	0	0	12B					
		75	75	0	0	0	12B					
#N/A		76	76	0	0	0	12B					
		77	77	0	0	0	12B					
		78	78	0	0	0	12B					
		79	79	0	0	0	12B					
		80	80	0	0	0	12B					
		81	81	0	0	0	12B					
		82	82	0	0	0	12B					
		83	83	0	0	0	12B					
		84	84	0	0	0	12B					
		85	85	0	0	0	12B					
		86	86	0	0	0	12B					
		87	87	0	0	0	12B					
		88	88	0	0	0	12B					
		89	89	0	0	0	12B					
		90	90	0	0	0	12B					
		91	91	0	0	0	12B					
		92	92	0	0	0	12B					
		93	93	0	0	0	12B					
		94	94	0	0	0	12B					
		95	95	0	0	0	12B					
		96	96	0	0	0	12B					

Calculation of Base Year, AKA Weighted Average Year

Base year:

Total of Column C/Total of Column B = Base Year

386309599.3

3480266.66

111

Base Year =

2011

=PG1!E14

Estimate of revised capital rate due to improvements 2000-20

Calculation of Base Year, AKA Weighted Average Year		
Base year:		
Total of Column C/Total of Column B = Base Year		
386309599.3	3480266.66	111
Base Year =		2011
=PG1!E14		
Estimate of revised capital rate due to improvements 2000-200?		

2

TABLE 2

#N/A

TABLE 3

TABLE 4

Construction Inflators by year and HSA

(Note: Use the 1960 Inflators for all years prior to 1960)

Property Tax Inflator

Table 2 column

ue

1, 2, 3, 4, 5, 10 & 11

Year

1, 2 & 10

3, 4 & 5

11

6, 7, 8 & 9

HSA

Rate

HSA

Column

3766

1960

6.26

6.08

6.29

6.54

1

1.05723

1

1

4896

1961

5.67

5.52

5.66

5.87

2

1.0395

2

1

6026

1962

5.67

5.52

5.66

5.87

3

1.0333

3

2

7155

1963

5.67

5.52

5.66

5.87

4

1.03302

4

2

8285

1964

5.67

5.52

5.66

5.87

5

1.03753

5

2

9415

1965

5.67

5.52

5.66

5.87

6

1.02368

6

4

10545

1966

5.36

5.23

5.35

5.55

7

1.02054

7

4

11675

1967

5.1

4.97

5.08

5.28

8

1.02613

8

4

12804

1968

4.85

4.71

4.83

5.03

9

1.01315

9

4

13934

1969

4.61

4.48

4.59

4.79

10

1.0815

10

1

15064

1970

4.38

4.25

4.36

4.56

11

1.03527

11

3

16194

1971

4.01

3.89

3.98

4.15