

		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: 0035246

Facility Name: Henderson County Retirement Center

Address: 604 Oakwood Drive Stronghurst 61480
Number City Zip Code

County: Henderson

Telephone Number: 309-924-1123 Fax # 309-924-1926

HFS ID Number:

Date of Initial License for Current Owners: 06/28/89

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501c3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: James G. Hull, C.P.A. Telephone Number: 217-228-1950
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) _____ (Date) _____
	(Title) _____
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) James G. Hull, C.P.A. Vice President
	(Firm Name & Address) WDM Computer Services, Inc. 1900 Harrison, Quincy, IL 62301
	(Telephone) 217-228-1950 Fax # 217-222-6053

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

Facility Name & ID Number Henderson County Retirement Center# 0035246 Report Period Beginning: 01/01/12 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 beds 04/23/12

	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>59</u>	Skilled (SNF)	<u>60</u>	<u>21,847</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>59</u>	TOTALS	<u>60</u>	<u>21,847</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>5,934</u>	<u>5,894</u>	<u>1,871</u>	<u>13,699</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>5,934</u>	<u>5,894</u>	<u>1,871</u>	<u>13,699</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 62.70%

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 ☒

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 06/28/89

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

YES ☒Date 05/16/89NO ☐

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

YES ☒NO ☐

If YES, enter number

of beds certified 60and days of care provided 1,871Medicare Intermediary National Government Services, Inc.

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	137,447	12,224	6,266	155,937		155,937		155,937			1
2	Food Purchase		105,645		105,645		105,645	(1,287)	104,358			2
3	Housekeeping	52,497	7,766		60,263		60,263		60,263			3
4	Laundry	18,877	3,798	10,820	33,495		33,495		33,495			4
5	Heat and Other Utilities			56,684	56,684		56,684		56,684			5
6	Maintenance	47,719	8,678	38,919	95,316		95,316		95,316			6
7	Other (specify):*											7
8	TOTAL General Services	256,540	138,111	112,689	507,340		507,340	(1,287)	506,053			8
	B. Health Care and Programs											
9	Medical Director			14,580	14,580		14,580		14,580			9
10	Nursing and Medical Records	752,357	104,899	2,818	860,074	450	860,524	(1,961)	858,563			10
10a	Therapy	19,042	2,443	170,278	191,763		191,763		191,763			10a
11	Activities	51,338	5,699	1,475	58,512		58,512		58,512			11
12	Social Services	30,801	730	1,475	33,006		33,006		33,006			12
13	CNA Training			8,487	8,487		8,487		8,487			13
14	Program Transportation		13,148	2,145	15,293		15,293		15,293			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	853,538	126,919	201,258	1,181,715	450	1,182,165	(1,961)	1,180,204			16
	C. General Administration											
17	Administrative	59,157			59,157		59,157		59,157			17
18	Directors Fees											18
19	Professional Services			40,896	40,896	(450)	40,446		40,446			19
20	Dues, Fees, Subscriptions & Promotions			32,973	32,973		32,973	(17,705)	15,268			20
21	Clerical & General Office Expenses	27,670	12,995	12,553	53,218		53,218		53,218			21
22	Employee Benefits & Payroll Taxes			175,143	175,143		175,143		175,143			22
23	Inservice Training & Education			3,385	3,385		3,385		3,385			23
24	Travel and Seminar			3,798	3,798		3,798		3,798			24
25	Other Admin. Staff Transportation		1,461		1,461		1,461		1,461			25
26	Insurance-Prop.Liab.Malpractice			42,429	42,429		42,429		42,429			26
27	Other (specify):*			4,562	4,562		4,562	(100)	4,462			27
28	TOTAL General Administration	86,827	14,456	315,739	417,022	(450)	416,572	(17,805)	398,767			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,196,905	279,486	629,686	2,106,077		2,106,077	(21,053)	2,085,024			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			122,242	122,242		122,242	(11,996)	110,246			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,848	56,848		56,848	(4,238)	52,610			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			600	600		600		600			34
35	Rent-Equipment & Vehicles			4,851	4,851		4,851		4,851			35
36	Other (specify):*											36
37	TOTAL Ownership			184,541	184,541		184,541	(16,234)	168,307			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,877		33,877		33,877		33,877			39
40	Barber and Beauty Shops		98	4,860	4,958		4,958		4,958			40
41	Coffee and Gift Shops		6,508		6,508		6,508		6,508			41
42	Provider Participation Fee			170,974	170,974		170,974		170,974			42
43	Other (specify):*			30,570	30,570		30,570	(30,570)				43
44	TOTAL Special Cost Centers		40,483	206,404	246,887		246,887	(30,570)	216,317			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,196,905	319,969	1,020,631	2,537,505		2,537,505	(67,857)	2,469,648			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-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,287)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(1,961)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(4,238)	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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,570)	43		24
25	Fund Raising, Advertising and Promotional	(17,705)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(11,996)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (67,857)		\$	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))	\$ (67,857)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
Henderson County Retirement Center

Report Period Beginning: ID# 0035246
Ending: 01/01/12
12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lease Buy-out (Deprec Cost)	\$ (11,996)	30	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	(11,996)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/12 Ending: 12/31/12
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,287)	0	0	0	0	0	0	0	0	0	0	(1,287)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,287)	0	0	0	0	0	0	0	0	0	0	(1,287)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,961)	0	0	0	0	0	0	0	0	0	0	(1,961)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,961)	0	0	0	0	0	0	0	0	0	0	(1,961)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(17,705)	0	0	0	0	0	0	0	0	0	0	(17,705)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(100)	0	0	0	0	0	0	0	0	0	0	(100)	27
28	TOTAL General Administration	(17,805)	0	0	0	0	0	0	0	0	0	0	(17,805)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,053)	0	0	0	0	0	0	0	0	0	0	(21,053)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(11,996)	0	0	0	0	0	0	0	0	0	0	(11,996)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,238)	0	0	0	0	0	0	0	0	0	0	(4,238)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,234)	0	0	0	0	0	0	0	0	0	0	(16,234)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(30,570)	0	0	0	0	0	0	0	0	0	0	(30,570)	43
44	TOTAL Special Cost Centers	(30,570)	0	0	0	0	0	0	0	0	0	0	(30,570)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(67,857)	0	0	0	0	0	0	0	0	0	0	(67,857)	45

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

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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 Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/12 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	Security Savings		X	Mortgage	\$10,949.92	10/22/08	\$ 849,849	\$ 1,663,420	10/22/38	6.5000	\$ 53,126	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Bank of Stronghurst		X	Cash Flow	Interest	10/21/11	125,000		06/19/12	2.8000	1,640	6	
7	Bank of Stronghurst		X	Cash Flow	Interest	12/28/11	25,000		06/19/12	2.8000	328	7	
8	See List Attached										1,754	8	
9	TOTAL Facility Related				\$10,949.92		\$ 999,849	\$ 1,663,420			\$ 56,848	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 999,849	\$ 1,663,420			\$ 56,848	15	

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

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

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2011 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.)	\$		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. (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.	\$		7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2007 _____	8	
	2008 _____	9	
	2009 _____	10	
	2010 _____	11	
	2011 _____	12	

	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	<u>Henderson County Retirement Center</u>	COUNTY	<u>Henderson</u>
---------------	---	--------	------------------

FACILITY IDPH LICENSE NUMBER 0035246

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 Applicable to 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: 18,636

B. General Construction Type: Exterior Brick Frame Wood/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).

Rental House, Non-Healthcare Related Rental

Supportive Living Facility, 20 Beds

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	Care Related	217,600	1988	\$ 15,000	1
2					2
3	TOTALS	217,600		\$ 15,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	60		1989	1988	\$ 1,260,000	\$ 42,031	30	\$ 42,000	\$ (31)	\$ 990,299
5	6		2000	2000	530,989	13,301	40	13,275	(26)	164,323
6										
7										
8										
	Improvement Type**									
9	PARKING LOT/LANDSCAPING		1989		25,102		20			25,102
10	LANDSCAPING		1990		937		20			937
11	LAND IMPROVEMENT		1995		1,839	92	20	92		1,640
12	BRICK SIGN		1996		12,915	620	20	646	26	10,640
13	LAND IMPROVEMENT		1992		2,003	84	20	92	8	2,003
14	LIGHTNING RODS		1998		3,600	240	15	240		3,500
15	NEW SOFFITS		1998		26,138	1,752	15	1,743	(9)	25,408
16	PHONE SYSTEM		1998		6,738	449	15	449		6,476
17	SIDE WALKS		1998		4,500	226	20	225	(1)	3,201
18	ALARM SYSTEM		1998		8,266		10			8,266
19	LAUNDRY/GARAGE BLDG		1999		50,330	3,374	15	3,355	(19)	44,988
20	STORAGE BLDG		1999		8,911	597	15	594	(3)	7,965
21	NEW ROOF		1999		16,311	1,094	15	1,087	(7)	14,306
22	LANDSCAPING		2000		1,706	85	20	85		1,038
23	FURNICE		2001		2,848		10			2,848
24	NEW EXIT		2001		1,645	110	15	110		1,296
25	LANDSCAPING		2002		954	32	10	32		954
26	GARAGE/STORAGE BUILDING		2002		12,800	858	15	853	(5)	8,938
27	ROOFING/SHINGLES		2003		17,838	1,192	15	1,189	(3)	11,283
28	Walk-in Freezer		2007		20,883	1,044	20	1,044		5,308
29	Window Tinting		2007		2,985	150	20	149	(1)	774
30	Door Closures		2007		4,345	434	10	434		2,245
31	Window Tinting		2008		1,164	58	20	58		281
32	Generator		2009		101,961	5,098	20	5,098		18,268
33	Fire Sprinkler		2010		17,425	1,162	15	1,162		2,904
34	Sprinkler Heads		2011		17,425	1,162	15	1,162		2,033
35	Parking Lot/Driveway		2011		30,280	2,030	15	2,019	(11)	3,383
36	Wing Remodel		2012		23,664	399	20	395	(4)	399

*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	Dining Room Paint	2012	\$ 5,415	\$ 23	20	\$ 23	\$	\$ 23	37
38	Dining Room Flooring	2012	18,677	78	20	78		78	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)		\$ 2,240,594	\$ 77,775		\$ 77,689	\$ (86)	\$ 1,371,107	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	\$177,427	\$18,081	\$18,081	\$	8	\$125,399	71
72	Current Year Purchases	80,795	2,273	2,273		12	2,273	72
73	Fully Depreciated Assets	547,560				8	547,560	73
74								74
75	TOTALS	\$805,782	\$20,354	\$20,354	\$		\$675,232	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	Patient Transport	07 Dodge Caravan	2007	\$17,725	\$1,477	\$1,477	\$	5	\$17,725	76
77	Patient Transport	06 Ford e450	2011	35,095	7,019	7,019		5	29,831	77
78	Maintenance and Snow Remo	1995 Ford F250	2011	9,000	1,800	1,800		5	3,150	78
79	Patient Transport	Van	2012	9,105	1,821	1,821		5	1,821	79
80	TOTALS			\$70,925	\$12,117	\$12,117	\$		\$52,527	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)	\$3,132,301	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$110,246	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$110,160	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(86)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,098,866	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	Rental Property	\$68,955	\$2,344	\$12,111	86
87	Rental Property	4,597	156	755	87
88	Supportive Living	1,732,106	52,915	168,732	88
89					89
90					90
91	TOTALS	\$1,805,658	\$55,415	\$181,598	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

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.
13.
14.
- /2013
- /2014
- /2015
- \$
- \$
- \$

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: \$4,851
- Description: Oxygen (\$2751.02), Copier Rent (\$2100.00)
- (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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

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	\$	776	\$ 62,939	\$	776	\$ 62,939	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		152	14,126		152	14,126	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		922	83,387		922	83,387	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				33,877		33,877	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			\$	1,850	\$ 160,452	\$ 33,877	1,850	\$ 194,329	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	\$ 141,277	\$ 166,157	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	560,474	623,522	3
4	Supply Inventory (priced at <u>FIFO</u>)	28,196	30,700	4
5	Short-Term Investments	390,005	390,005	5
6	Prepaid Insurance	9,914	19,680	6
7	Other Prepaid Expenses	3,493	5,012	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,133,359	\$ 1,235,076	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500	22,500	13
14	Buildings, at Historical Cost	2,507,030	4,241,188	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	986,997	1,058,496	16
17	Accumulated Depreciation (book methods)	(2,335,635)	(2,517,234)	17
18	Deferred Charges		(28,590)	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: <u>CIP</u>)	1,181	1,181	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,182,073	\$ 2,777,541	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,315,432	\$ 4,012,617	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 105,816	\$ 110,642	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	92,506	107,600	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,332	2,332	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,305	32
33	Accrued Interest Payable	4,323	8,585	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>PAYROLL WITHHOLDINGS</u>	4,682	4,682	36
37	<u>ROUNDING</u>		(1)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 409,659	\$ 435,145	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	816,406	2,309,475	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)	\$ 816,406	\$ 2,309,475	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,226,065	\$ 2,744,620	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,089,367	\$ 1,267,997	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,315,432	\$ 4,012,617	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,207,836	1
2	Restatements (describe):		2
3	Prior Year Adjustment	(57)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,207,779	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(27,966)	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) Rental Profit	(1,029)	15
16	Other (describe) Supportive Living Profit	89,213	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 60,218	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)	\$ 1,267,997	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Henderson County Retirement Center# 0035246Report Period Beginning: 01/01/12Ending: 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	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,296,718	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,296,718	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	67,852	6
7	Oxygen	100	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 67,952	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	6,145	12
13	Barber and Beauty Care	4,795	13
14	Non-Patient Meals	1,287	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,015	17
18	Sale of Supplies to Non-Patients	1,961	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	720	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,923	23
	D. Non-Operating Revenue		
24	Contributions	117,642	24
25	Interest and Other Investment Income***	4,238	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 121,880	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See List Attached</u>	7,066	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,066	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,509,539	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	507,340	31
32	Health Care	1,182,165	32
33	General Administration	416,572	33
	B. Capital Expense		
34	Ownership	184,541	34
	C. Ancillary Expense		
35	Special Cost Centers	75,913	35
36	Provider Participation Fee	170,974	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,537,505	40
41	Income before Income Taxes (line 30 minus line 40)**	(27,966)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (27,966)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 732,043	44
45	Private Pay - Net Inpatient Revenue	835,731	45
46	Medicare - Net Inpatient Revenue	728,944	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,296,718	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	2,030	2,160	\$ 53,523	\$ 24.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,330	4,637	98,767	21.30	3
4	Licensed Practical Nurses	12,343	13,436	225,530	16.79	4
5	CNAs & Orderlies	32,055	33,862	317,380	9.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,805	1,884	19,042	10.11	8
9	Activity Director	1,661	1,904	26,955	14.16	9
10	Activity Assistants	2,406	2,798	24,383	8.71	10
11	Social Service Workers	2,478	2,828	30,801	10.89	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,088	26,928	12.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,835	5,065	45,447	8.97	15
16	Dishwashers	6,672	7,294	65,072	8.92	16
17	Maintenance Workers	2,963	3,242	47,719	14.72	17
18	Housekeepers	5,876	6,109	52,497	8.59	18
19	Laundry	1,520	1,735	18,877	10.88	19
20	Administrator	1,909	2,284	59,157	25.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,825	1,961	27,670	14.11	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					31
32	Other Health Care Care Plan Coord	1,799	2,509	57,157	22.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,443	95,796	\$ 1,196,905 *	\$ 12.49	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	165	\$ 6,266	1-3	35
36	Medical Director	Contract	14,580	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,978	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	1,475	11-3	44
45	Social Service Consultant	Contract	1,475	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	165	\$ 25,774		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.

STATE OF ILLINOIS

0035246

Report Period Beginning:

01/01/12

Ending:

12/31/12

Facility Name & ID Number

Henderson County Retirement Center

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Clifton	Administrator	0	\$ 57,157
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,157

B. Administrative - Other

Description	Amount
n/a	\$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
WDM Computer Services, Inc	Data Processing	\$ 19,683
WDM Computer Services, Inc	Consulting	16,320
Bennet and Middendorf	Audit Services	3,600
Fort and Neff	Legal	218
Barash & Everett, LLC	Legal	0
Davis And Campbell	Legal	605
Bonnie Henry	Signing	20
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 40,446

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 39,393
Unemployment Compensation Insurance	5,904
FICA Taxes	88,532
Employee Health Insurance	41,017
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer's IRA Match	13,466
Vacation Accrual Adjustment	(15,256)
Employee Life Ins.	1,220
Employee Flu Shots	576
Employee Recognition	291
TOTAL (agree to Schedule V, line 22, col.8)	\$ 175,143

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
n/a		\$ 0
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 2,322
Advertising: Employee Recruitment	5,227
Health Care Worker Background Check (Indicate # of checks performed)	594
Patient Background Checks	1,244
Advertising/Public Relations	17,705
See List Attached	4,910
Employee Drug Testing	971
Less: Public Relations Expense	(17,705)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,268

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
See List Attached	3,798
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,798

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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

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

XX. GENERAL INFORMATION:

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

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

If YES, give association name and amount. LSN/Leading Edge \$2,692.77

(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? Yes

If YES, what is the capacity? 60

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

What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,004 Line 10-2

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

If NO, attach a complete explanation. _____

(8) Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ 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. \$ 170,974

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? Yes

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. \$ 1,287

(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? Yes

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 393

c. What percent of all travel expense relates to transportation of nurses and patients? 90

d. Have vehicle usage logs been maintained? Yes

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

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

g. Does the facility transport residents to and from day training? No

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

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

Firm Name: Bennet and Middendorf

(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

Henderson County Retirement Center, Inc.
#0035246
01/01/12 to 12/31/12

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$1,031.92
REPAIRS & MAINT LAUNDRY	\$680.07
REPAIRS & MAINT HSK	\$0.00
OUTSIDE SERVICES	\$7,550.88
REPAIRS & MAINT BUILDING	\$9,051.90
REPAIRS & MAINT EQUIP	\$1,915.35
REPAIRS & MAINT GROUNDS	\$1,092.75
REFUSE	\$16,067.29
REPAIRS & MAINT GEN/ADM	\$1,528.67

TOTAL	<u>\$38,918.83</u>
-------	--------------------

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$7,330.70
Board Minutes	\$320.00
Software Support	\$3,780.00
IVANS Medicare Billings	\$1,122.38
TOTAL	<u>\$12,553.08</u>

Schedule V. Line 14 & 25, Column 2 (90% to line 14)

Auto Exp. & Service	\$2,674.02
Auto Gas & Oil	\$11,135.81
Business Mileage Expense	<u>\$798.74</u>
	<u>\$14,608.57</u>

Schedule V. Line 43, Column3

Bad Debt	\$30,569.50
Rounding	<u>\$30,569.50</u>

Schedule V. Line 27, Column3

Data Process-Internet	\$1,590.42
Contributions	\$100.00
Misc Exp.	\$2,734.57
bank fees	<u>\$137.28</u>
	<u>\$4,562.27</u>

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Transportation Income-Pvt	\$1,752.50
Transportation Income-IDPA	\$393.26
Suppliments	\$2,685.00
WheelChair Rental	\$0.00
Admission Income	\$600.00
Uniform Sales	\$39.00
Activities Program Income	\$0.00
Personal Purchase income	\$2.25
Gain or Loss on Sale of Asset	\$100.00
Rebates	\$0.00
Dues	\$1,700.00
Misc. Income	-\$208.09
Rounding	<u>\$2.00</u>
	<u><u>\$7,065.92</u></u>

Schedule XIX, Section F.

IDPH	Sanitation Lic.	\$35.00
IL Charity Buraeu	990-g Fee	\$15.00
AANAC Renewal Fee	Dues	\$110.00
CLIAL	CLIA Fee	\$150.00
Stronghurst Booster	Dues	\$40.00
Secretary of State	Fees	\$218.00
Long Term Care Nurses Assoc	Dues	\$50.00
Life Services Network	Dues	\$1,966.30

Leading Edge	Dues	\$726.47
Misc Subscriptions	Subscriptions	\$1,599.24
Rounding		<u>\$4,910.01</u>

Henderson County Retirement Center, Inc.

#0035246

01/01/12 to 12/31/12

Board Members

Diana Doran, Pres
Box 417
Carman, IL 61425

Judy Roessler
RR1, Box 11
Media, IL 61460

Sally Fisher
RR 1
Lomax, IL 61454

Tom Edmonds
RR 1, Box 129
Lomax, IL 61454

Mary Reed, Treas.
RR 1, Box 80
Little York, IL 61453

Tom Pullen
Box 199
Gladstone, IL 61437

Nancy Stevenson, Sec.
RR 1
Gladstone, IL 61437

David Gerst
RR 1, Box 111
Lomax, IL 61454

Ralph Tatge, Vice Pres.
Box 535
Stronghurst, IL 61480

Honorary Board Members

Laura Kent Donahue
Zach Stamp

Diana Doran's insurance agency is the agent for the Commercial Package Policy.
The agency also provides the surety bond for the nursing home.

Henderson County Retirement Center, Inc.
#0035246
01/01/12 to 12/31/12

Reclassifications

- 1 Reclassify \$449.52 from Professional fees to Psychiatric services for costs of Psychiatric program.
- 2 Reclassify \$
- 3 Reclassify \$
- 4 Reclassify \$
- 5 Reclassify \$
- 6 Reclassify \$

Henderson County Retirement Center, Inc.
#0035246
01/01/12 to 12/31/12

Name of Lender	Related**		Purpose of Loan	Payment Required	Date of Note	Amount of Note		Maturity Date	Rate (4 Digits)	Interest Expense
	YES	NO				Original	Balance			
Bank of Stronghurst		X	Cash Flow	Interest	9/12/2012	\$25,000.00	\$25,000.00	6/19/2013	2.6500%	\$188.76
Bank of Stronghurst		X	Cash Flow	Interest	10/1/2012	\$50,000.00	\$50,000.00	3/19/2013	2.5500%	\$324.86
Bank of Stronghurst		X	Cash Flow	Interest	10/5/2012	\$25,000.00	\$25,000.00	3/19/2013	2.5500%	\$155.44
Bank of Stronghurst		X	Cash Flow	Interest	11/21/2012	\$50,000.00	\$50,000.00	3/19/2013	2.5500%	\$146.71
Bank of Stronghurst		X	Cash Flow	Interest	12/7/2012	\$50,000.00	\$50,000.00	3/19/2013	2.5500%	\$90.82
Bank of Stronghurst		X	Cash Flow	Interest	6/19/2012	\$125,000.00	\$0.00	3/19/2013	2.5500%	\$183.39
Bank of Stronghurst		X	Cash Flow	Interest	1/31/2012	\$50,000.00	\$0.00	6/19/2012	2.8000%	\$479.45
Bank of Stronghurst		x	Cash Flow	Interest	6/19/2012	\$50,000.00	\$0.00	3/19/2013	2.5500%	\$48.90
Bank of Stronghurst		x	Cash Flow	Interest	6/19/2012	\$25,000.00	\$0.00	3/19/2013	2.5500%	\$24.45
Bank of Stronghurst		x	Cash Flow	Interest	5/21/2012	\$50,000.00	\$0.00	6/19/2012	2.8000%	\$111.23
						\$500,000.00	\$200,000.00			\$1,754.01

Henderson County Retirement Center, Inc.
#0035246
01/01/12 to 12/31/12

2012 Census

Pvt Pay	Medicaid	Medicare	Totals	Total columus
558	560	124	1242	2484
504	463	124	1091	2182
522	500	146	1168	2336
475	514	117	1106	2212
522	476	166	1164	2328
505	448	127	1080	2160
505	511	194	1210	2420
496	530	199	1225	2450
454	538	110	1102	2204
439	528	116	1083	2166
420	433	230	1083	2166
494	433	218	1145	2290
				0
5894	5934	1871	13699	27398

Check Date	When Attended	Vendor Name	Name of In-Service	Amount
7/30/2012	08/1 & 08/2/12	Insightful Food	Insightful Food Safety	\$ 198.00
8/8/2012	8/13/2012	Polaris Group	Denial Letters & Generic Notices for LTC	\$ 159.00
8/22/2012	8/22/2012	Med Pass, Inc.	Nursing Home Policies & Procedures	\$ 510.84
9/10/2012	9/20/2012	Polaris Group	Medicare Documentation & Skilling Criteria	\$ 159.00
9/12/2012	10/11/2012	Polaris Group	COT, SOT, EOT Combinations & More - Pt. 2	\$ 159.00
9/10/2012	10/4/2012	Polaris Group	Medicare Basics	\$ 159.00
11/1/2012	11/13/2012	Polaris Group	Survey Process - Tasks 1-5 - New Quality Measures	\$ 159.00
11/1/2012	11/27/2012	Polaris Group	Writing A Plan Of Correction	\$ 159.00
11/1/2012	11/8/2012	Polaris Group	Staffing, Scheduling & Budget	\$ 159.00
1/1/2012	11/20/2012	Polaris Group	Survey Process - Tasks 5-7 - Staff Preparation	\$ 159.00
12/7/2012	12/7/2012	Spoon River College	Train the Trainer-C.n.a. Instructor Course	\$ 450.00
12/11/2012	12/12/2012	Polaris Group	MDS 3.0 Part 1: Basics & More	\$ 159.00
12/12/2012	12/13/2012	Polaris Group	MDS 3.0 Part 2: Clinical Nursing Sections	\$ 159.00
12/12/2012	12/19/2012	Polaris Group	MDS 3.0 Part 4: Interviews & MDS Coding	\$ 159.00
12/12/2012	12/20/2012	Polaris Group	MDS 3.0 Part 5: Care Area Assessments	\$ 159.00
12/7/2012	12/11/2012	Polaris Group	Triple Check & More	\$ 159.00
12/12/2012	12/18/2012	Polaris Group	MDS 3.0 Part 3: Sections G & O	\$ 159.00
Total for Year				\$ 3,384.84

Check Date	Who Attended	When Attended	Where Attended	Name of Seminar	Expense	Amount
1/4/2012	Jennifer Schaley	1/12/2012	Carol Stream, IL	Activity Assistant Training Program	Registration	\$ 75.00
2/16/2012	Jennifer Schaley	1/12/2012	Carol Stream, IL	Activity Assistant Training Program	Mileage	\$ 60.00
7/12/2012	Irene Francis, Jennifer Schaley, Carla Carnes	7/11/2012	LaClaire, IA	Don't Miss the Moonshine Lunch & Learn	Registration	\$ 25.00
8/10/2012	Jennifer Schaley; Carole Dillon; Amy Franklin	7/23/2012	Moline, IL	Ramirez Consulting Group Semi Annual Update	Registration	\$ 295.00
7/23/2012	Jennifer Schaley, Irene Francis, Dianne Kircher, Richard Clifton, Paige Lafary, & Sharon Annegers,	7/23/2012	Stronghurst Amb. Bldg	Learning about Evaluations and How to Present Ther	Donuts	\$ 26.97
7/25/2012	Jennifer Schaley, Irene Francis, Dianne Kircher, Richard Clifton, Paige Lafary, & Sharon Annegers,	7/23/2012	Stronghurst Amb. Bldg	Learning about Evaluations and How to Present Ther	Gift Cert. for Instructor	\$ 25.00
7/26/2012	Jennifer Schaley, Irene Francis, Dianne Kircher, Richard Clifton, Paige Lafary, & Sharon Annegers,	7/23/2012	Stronghurst Amb. Bldg	Learning about Evaluations and How to Present Ther	Meal	\$ 63.30
8/6/2012	Christine Pearson	8/16/2012	Galesburg, IL	Restorative Nursing Assistant Training	Registration	\$ 120.00
8/9/2012	Sharon Annegers; Amy Franklin; Jamie Roberts; Donna Peterson; Paige Lafary; Julie Allen	9/5/2012	Stronghurst Christian Church	Safety Training	Registration	\$ 300.00
8/30/2012	19 employees attended CPR Training	8/30/2012	Stronghurst Amb. Bldg	CPR Training	Registration	\$ 361.00
8/30/2012	Jennifer Schaley, Richard Clifton; Irene Francis; Carole Dillon; Amy Franklin; Dianne Kircher	8/31/2012	Rock Island, IL	WIAAA Annual Conference	Registration	\$ 240.00
9/12/2012	Dianne Kircher; Bobbi Tapscott; Richard Clifton; Paige Lafary	9/25/2012	Springfield, IL	Criminal History Record Information Training Symposium For Non-Criminal Justice Users	Registration	\$ 100.00
9/12/2012	Dianne Kircher; Bobbi Tapscott; Richard Clifton; Paige Lafary	9/25/2012	Springfield, IL	Criminal History Record Information Training Symposium For Non-Criminal Justice Users	Gas	\$ 38.74
10/12/2012	Dianne Kircher, Bobbi Tapscott	10/18/2012	Springfield, IL	New Medicaid Eligibility: SMART & Beyond	Registration	\$ 110.00
11/12/2012	Jennifer Schaley; Carole Dillon; Amy Franklin	11/2/2012	Moline, IL	QIS Training	Registration	\$ 295.00
10/16/2012	Alicia Anderson	11/5-7-12	St. Louis, MO	Medicare Training Workshop for LTC	Registration	\$ 929.00
11/5/2012	Alicia Anderson	11/5-7/2012	St. Louis, MO	Medicare Training Workshop for LTC	Hotel	\$ 417.81
11/5/2012	Alicia Anderson	11-5-7-12	St. Louis, MO	Medicare Training Workshop for LTC	Parking	\$ 36.00
11/28/2012	Alicia Anderson	11/5-7/12	St. Louis, MO	Medicare Training Workshop for LTC	Batteries	\$ 5.41
11/28/2012	Alicia Anderson	11/5-7/12	St. Louis, MO	Medicare Training Workshop for LTC	Meals	\$ 8.62
11/28/2012	Alicia Anderson	11/5-7/12	St. Louis, MO	Medicare Training Workshop for LTC	Mileage	\$ 190.80
11/5/2012	Alicia Anderson	11/5-7/12	St. Louis, MO	Medicare Training Workshop for LTC	Meals	\$ 75.00
Total for Year 2012						\$ 3,797.65