

		FOR BHF USE					

LL1

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
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I. IDPH License ID Number: <u>0037846</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Hickory Street Place</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3905 East Hickory Street</u> <u>Decatur</u> <u>62521</u>																									
Number City Zip Code																									
County: <u>Macon</u>																									
Telephone Number: <u>217-422-8231</u> Fax # (<u>217</u>) <u>763-2101</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>David M. Jacobus</u></td></tr><tr><td>(Title) <u>Owner</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Mark S. Wood, CPA</u></td></tr><tr><td>(Firm Name & Address) <u>May, Cocagne & King, P.C.</u></td></tr><tr><td><u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u></td></tr><tr><td>(Telephone) <u>217-875-2655</u> Fax # <u>217-875-1660</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David M. Jacobus</u>	(Title) <u>Owner</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Mark S. Wood, CPA</u>	(Firm Name & Address) <u>May, Cocagne & King, P.C.</u>	<u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u>	(Telephone) <u>217-875-2655</u> Fax # <u>217-875-1660</u>												
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Date of Initial License for Current Owners: <u>5/24/93</u>																									
Type of Ownership:																									
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In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Mark S. Wood, CPA</u> Telephone Number: <u>217-875-2655</u>																									
Email Address: _____																									

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I. IDPH License ID Number: <u>0038729</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Autumn Leaves, Inc. d/b/a/ Beacon Street Place</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>4838 Beacon Drive</u> <u>Decatur</u> <u>62521</u>			
Number City Zip Code			
County: <u>Macon</u>			
Telephone Number: <u>217-422-1761</u> Fax # (<u>217</u>) <u>763-2101</u>			
HFS ID Number: <u>37-1273581</u>			
Date of Initial License for Current Owners: <u>5/24/93</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☐ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mark S. Wood, CPA</u>			
Telephone Number: <u>217-875-2655</u>			
Email Address: <u>mwood@mckcpa.com</u>			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>David M. Jacobus</u>	
		(Title) <u>Owner</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) <u>Mark S. Wood, CPA</u>	
		(Firm Name & Address) <u>May, Cocagne & King, P.C.</u>	
		<u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u>	
		(Telephone) <u>217-875-2655</u> Fax # <u>217-875-1660</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

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I. IDPH License ID Number: <u>0036764</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Autumn Leaves, Inc. d/b/a/ Forty-Fourth Street Place</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Street Place

0037846 Report Period Beginning: 1/1/12 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 3/21/91

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,669			5,669	13
14	TOTALS	5,669			5,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.07%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

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

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

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

I. On what date did you start providing long term care at this location? Date started 05/24/93

J. Was the facility purchased or leased after January 1, 1978? YES X Date 05/24/93 NO

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

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/12 Fiscal Year:

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

SEE ACCOUNTANTS' COMPILATION REPORT

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
	A. General Services	1	2	3	4	5	6	7	8	9	10
1	Dietary	8,998	1,127	3,814	13,939		13,939		13,939		1
2	Food Purchase		46,164		46,164	(4,847)	41,317		41,317		2
3	Housekeeping	76,341	4,177		80,518		80,518		80,518		3
4	Laundry		960		960		960		960		4
5	Heat and Other Utilities			22,776	22,776		22,776	3,333	26,109		5
6	Maintenance	13,772	2,106	11,324	27,202		27,202	598	27,800		6
7	Other (specify):*			8,339	8,339		8,339		8,339		7
8	TOTAL General Services	99,111	54,534	46,253	199,898	(4,847)	195,051	3,931	198,982		8
	B. Health Care and Programs										
9	Medical Director			7,933	7,933		7,933		7,933		9
10	Nursing and Medical Records	234,179	9,577	5,454	249,210		249,210	1,588	250,798		10
10a	Therapy										10a
11	Activities	29,714	3,538		33,252		33,252		33,252		11
12	Social Services	77,266		350	77,616		77,616		77,616		12
13	CNA Training	1,407			1,407		1,407		1,407		13
14	Program Transportation			10,042	10,042		10,042		10,042		14
15	Other (specify):*			179,507	179,507		179,507	(173,746)	5,761		15
16	TOTAL Health Care and Programs	342,566	13,115	203,286	558,967		558,967	(172,158)	386,809		16
	C. General Administration										
17	Administrative	58,280			58,280		58,280		58,280		17
18	Directors Fees										18
19	Professional Services			22,018	22,018		22,018	801	22,819		19
20	Dues, Fees, Subscriptions & Promotions			1,618	1,618		1,618		1,618		20
21	Clerical & General Office Expenses	10,962	2,751	14,419	28,132		28,132	(6,260)	21,872		21
22	Employee Benefits & Payroll Taxes			68,341	68,341	4,847	73,188		73,188		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,070	1,070		1,070		1,070		24
25	Other Admin. Staff Transportation			150	150		150		150		25
26	Insurance-Prop.Liab.Malpractice			13,053	13,053		13,053		13,053		26
27	Other (specify):*										27
28	TOTAL General Administration	69,242	2,751	120,669	192,662	4,847	197,509	(5,459)	192,050		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	510,919	70,400	370,208	951,527		951,527	(173,686)	777,841		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			12,369	12,369		12,369	19,263	31,632			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,514	7,514		7,514		7,514			32
33	Real Estate Taxes			19,019	19,019		19,019		19,019			33
34	Rent-Facility & Grounds			73,200	73,200		73,200	(73,200)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			112,102	112,102		112,102	(53,937)	58,165			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			57,601	57,601		57,601		57,601			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			57,601	57,601		57,601		57,601			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	510,919	70,400	539,911	1,121,230		1,121,230	(227,623)	893,607			45

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

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		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	(173,746)	15		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	6,360	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,386)		\$	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)	(60,237)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (60,237)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (227,623)		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	Therapy		X			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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Hickory Street Place

Report Period Beginning: ID# 0037846

Ending: 1/1/12

12/31/12

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
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42				42
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44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Street Place # 0037846 Report Period Beginning: 1/1/12 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	0	0	0	0	0	0	0	0	0	0	0	0	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	3,333	0	0	0	0	0	0	0	0	0	3,333	5
6	Maintenance	0	598	0	0	0	0	0	0	0	0	0	598	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	3,931	0	0	0	0	0	0	0	0	0	3,931	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	0	1,588	0	0	0	0	0	0	0	0	0	1,588	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):*	(173,746)	0	0	0	0	0	0	0	0	0	0	(173,746)	15
16	TOTAL Health Care and Programs	(173,746)	1,588	0	0	0	0	0	0	0	0	0	(172,158)	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	801	0	0	0	0	0	0	0	0	0	801	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	(6,260)	0	0	0	0	0	0	0	0	0	(6,260)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(5,459)	0	0	0	0	0	0	0	0	0	(5,459)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(173,746)	60	0	0	0	0	0	0	0	0	0	(173,686)	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	6,360	0	12,903	0	0	0	0	0	0	0	0	19,263	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(73,200)	0	0	0	0	0	0	0	0	(73,200)	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	6,360	0	(60,297)	0	0	0	0	0	0	0	0	(53,937)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(167,386)	60	(60,297)	0	0	0	0	0	0	0	0	(227,623)	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
David M. Jacobus	100	Drew Corp d/b/a/ Moultrie County Comm Center	Decatur, IL	David Jacobus	Decatur, IL	Central Office
				Central Office		for homes

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	21	General Office	\$ 7,500	David M. Jacobus, Central Office	100.00%	\$ 1,240	\$ (6,260)	1
2	V	5	Utilities				3,333	3,333	2
3	V	6	Maintenance				598	598	3
4	V	10	Medical Supplies				1,588	1,588	4
5	V	19	Professional Fees				801	801	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			\$ 7,500			\$ 7,560	\$ * 60	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Building Rent	\$27,600	David M. Jacobus	100.00%	\$	\$(27,600)	15
16	V	30	Depreciation			100.00%	5,081	5,081	16
17	V								17
18	V	34	Building Rent	22,800		100.00%		\$(22,800)	18
19	V	30	Depreciation			100.00%	2,745	2,745	19
20	V								20
21	V	34	Building Rent	22,800		100.00%		\$(22,800)	21
22	V	30	Depreciation			100.00%	5,077	5,077	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$73,200			\$12,903	\$*(60,297)	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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	David M. Jacobus	Owner	Various	100.00	26,000	6.5	16.25	Dietary	\$ 6,760	1-1	1
2						13	32.50	Maintenance	15,437	6-1	2
3						10.5	26.25	General Office	10,920	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 33,117		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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Fifth Third Bank		X	2010 Jeep Grnad Cherokee	\$1,400.00	2/24/11	\$ 25,662	\$	9/10/12	3.8000	\$ 183	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	PNC Bank		X	Operating Cash	N/A	7/30/12	350,000	110,000	7/29/13	3.2500	7,331	6	
7												7	
8												8	
9	TOTAL Facility Related				\$1,400.00		\$ 375,662	\$ 110,000			\$ 7,514	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 375,662	\$ 110,000			\$ 7,514	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.) SEE ACCOUNTANTS' COMPILATION REPORT

** 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.		\$	11,000	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.)				\$	14,618	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	3,618	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	15,401	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.				\$	19,019	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2007	8,586	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>			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
	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																							
		2008	8,815	9																						
		2009	10,511	10																						
		2010	10,475	11																						
		2011	14,618	12																						
2012 Accrual Based on 2011 Taxes																										

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.**

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Hickory Street Place

COUNTY

Macon

FACILITY IDPH LICENSE NUMBER

0037846

CONTACT PERSON REGARDING THIS REPORT

David M. Jacobus

TELEPHONE

217-763-2191

FAX #

217-763-2101

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	04-13-08-152-009	Hickory Street Place	\$ 8,211.42	\$ 8,211.42
2.	09-13-20-327-006	44th Street Place	\$ 3,420.46	\$ 3,420.46
3.	09-13-20-282-008	Beacon Street Place	\$ 2,986.56	\$ 2,986.56
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 14,618.44	\$ 14,618.44

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,400 B. General Construction Type: Exterior Vinyl Frame Wood w/ sprinklers Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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 (X) (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) 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	Nursing Facility	2,400	1998	\$ 27,000	1
2	From pages 11A & 11B			32,000	2
3	TOTALS	2,400		\$ 59,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet: 1,320

B. General Construction Type: Exterior Wood Frame Wood

Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelk 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 Compl 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).

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	Nursing Facility	1,320	1993	\$ 5,000	1
2					2
3	TOTALS	1,320		\$ 5,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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STATE OF ILLINOIS

Facility Name & ID Number Hickory Street Place

0037846

Report Period Beginning:

1/1/12

Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,176 **B. General Construction Type:** **Exterior** Brick **Frame** Wood **Number of Stories** _____

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 Compl 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).

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	Nursing Facility	2,176	1998	\$ 27,000	1
2					2
3	TOTALS	2,176		\$ 27,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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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	6		1998	1991	\$ 198,175	\$ 5,081	25	\$ 7,927	\$ 2,846	\$ 116,923
5	4		1993	1960	55,000	2,745	25	2,200	(545)	43,262
6	6		1998	1963	198,000	5,077	25	7,920	2,843	114,180
7										
8										
	Improvement Type**									
9	Landscaping		1991		549		10			550
10	Landscaping		1992		3,496		15			3,496
11	Landscaping		1995		519		15			519
12	Blinds and Curtains		1996		1,795		5			1,795
13	Landscaping		1996		2,418		10			2,418
14	Office Remodel		2001		2,000	51	15	133	82	1,522
15	Office Remodel		2001		2,000	51	15	133	82	1,522
16	Office Remodel		2001		1,000		10			1,000
17	HVAC		2006		4,623	119	15	308	189	1,978
18	Roof		2007		6,421	165	20	321	156	1,846
19	Siding & Windows		2011		4,000	103	20	200	97	233
20	Carpeting		2012		1,000	143	7	57	(86)	57
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
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioner	1995	\$ 1,051	\$ 27	8	\$	\$ (27)	\$ 1,051	37
38	Landscaping	1996	2,418		10			2,418	38
39	Furnace	1996	1,030	26	15		(26)	1,030	39
40	Landscaping	1996	2,101		10			2,101	40
41	Carpet/Blinds	1997	3,074		5			3,074	41
42	Security System	1993	2,259		15			2,259	42
43	Cabinets	1993	2,456		15			2,456	43
44	Office Remodel	1993	44,254		15			44,254	44
45	Sprinkler System	1993	7,800		15			7,800	45
46	Plumbing	1999	2,053	53	6		(53)	2,053	46
47	Office Remodel	2001	2,000	51	15	133	82	1,522	47
48	Office Remodel	2001	1,000		10			1,000	48
49	Roof	2006	10,275	263	10	1,028	765	6,508	49
50	Fire Panel	2008	2,675		5	235	235	2,675	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)		\$ 565,442	\$ 13,955		\$ 20,595	\$ 6,640	\$ 371,502	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 565,442	\$ 13,955		\$ 20,595	\$ 6,640	\$ 371,502	1
2	Asphalt Drive	1993	5,431		16			5,431	2
3	Landscaping	1996	2,418		10			2,418	3
4	Furnace	1999	1,285	33	15	86	53	1,149	4
5	Office Remodel - Walls	2001	2,000	51	15	133	82	1,522	5
6	Office Remodel - Flooring	2001	2,000		10			2,000	6
7	Roof	2006	12,611	323	10	1,261	938	7,987	7
8	Fire Panel	2008	2,675		10	235	235	2,675	8
9	Security System	2010	7,000	180	10	700	520	1,983	9
10	AC Unit	2011	2,152	78	20	108	30	126	10
11	Carpet Weavers	2011	1,573		10	157	157	171	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 604,587	\$ 14,620		\$ 23,275	\$ 8,655	\$ 396,964	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$44,408	\$	\$1,754	\$1,754	20-Mar	\$40,691	71
72	Current Year Purchases	4,248	316	187	(129)	10	187	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$48,656	\$316	\$1,941	\$1,625		\$40,878	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	Program Transportation	2004 Chevy Express G150	2004	\$24,490	\$	\$	\$		\$24,490	76
77	Program Transportation	2003 Town & Country	2004	16,305					16,305	77
78	Transportation	2008 Nissan Pathfinder	2007	36,882	2,124		(2,124)		36,882	78
79	Transportation	2010 Jeep Cherokee	2011	25,662	8,212	6,416	(1,796)		11,762	79
80	TOTALS			\$103,339	\$10,336	\$6,416	\$(3,920)		\$89,439	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)	\$815,582	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$25,272	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$31,632	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$6,360	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$527,281	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	1995 Pickup	\$47,007	\$	\$47,007	86
87	2003 Chevy Blazer	18,703		18,703	87
88	2004 Chevy Express	21,046		21,046	88
89					89
90					90
91	TOTALS	\$86,756	\$	\$86,756	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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)	\$			

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

D. NUMBER OF CNAs TRAINED

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

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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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 172,285	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	186,976		3
4	Supply Inventory (priced at)	3,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,205		6
7	Other Prepaid Expenses	275		7
8	Accounts Receivable (owners or related parties)	30,387		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 402,128	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	286,738		15
16	Equipment, at Historical Cost	48,656		16
17	Accumulated Depreciation (book methods)	(246,738)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 88,656	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 490,784	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 36,836	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	110,000		29
30	Accrued Salaries Payable	19,252		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,865		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,401		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 184,354	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 184,354	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 306,430	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 490,784	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 290,063	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 290,063	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	16,367	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 16,367	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)	\$ 306,430	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 962,905	1	
2Discounts and Allowances for all Levels	()	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 962,905	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	173,746	9	
10Other Government Grants		10	
11CNA Training Reimbursements	282	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)	\$ 174,028	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***	664	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 664	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28a		28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,137,597	30	

	2		
II. Expenses	Amount		
A. Operating Expenses			
31General Services	199,898	31	
32Health Care	558,967	32	
33General Administration	192,662	33	
B. Capital Expense			
34Ownership	112,102	34	
C. Ancillary Expense			
35Special Cost Centers		35	
36Provider Participation Fee	57,601	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,121,230	40	
41Income before Income Taxes (line 30 minus line 40)**	16,367	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 16,367	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? No 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	22,787	23,461	234,179	9.98	5
6	CNA Trainees	67	67	1,407	21.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,045	3,179	29,714	9.35	10
11	Social Service Workers	4,271	4,443	77,266	17.39	11
12	Dietician	390	390	8,998	23.07	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	775	775	13,772	17.77	17
18	Housekeepers	7,430	7,671	76,341	9.95	18
19	Laundry					19
20	Administrator	1,421	1,541	27,225	17.67	20
21	Assistant Administrator	1,602	1,602	31,055	19.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	395	395	10,962	27.75	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	42,183	43,524	\$ 510,919 *	\$ 11.74	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	109	\$ 3,814		35
36	Medical Director	Fee	7,933		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	13	671		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	26	1,183		43
44	Activity Consultant				44
45	Social Service Consultant	Fee	350		45
46	Other(specify) Psychologist	Fee	3,600		46
47					47
48					48
49	TOTAL (lines 35 - 48)	148	\$ 17,551		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Hickory Street Place

0037846Report Period Beginning: 1/1/12Ending: 12/31/12

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tracy Jones	Administrator	0	\$ 26,597
Valarie Poling	Administrator	0	10,000
Pam Rosenkranz	Administrator	0	6,090
Various Staff	Admin Asst	0	15,593
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,280

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne & King	Accounting/Bookkeeping	\$ 21,430
Samuels Miller	Legal	588
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 22,018

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 13,131	
Unemployment Compensation Insurance	5,952	
FICA Taxes	38,823	
Employee Health Insurance	10,435	
Employee Meals	4,847	
Illinois Municipal Retirement Fund (IMRF)*		
TOTAL (agree to Schedule V, line 22, col.8)		\$ 73,188

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment		
Health Care Worker Background Check (Indicate # of checks performed 10)	195	
License & Fees	742	
Dues & Subscriptions	681	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,618

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,070
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,070

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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.

N/A

(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.

\$ 57,601

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?

N/A

(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.

\$ 4,847

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

(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?

100

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

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

\$

(17)

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

No

Firm Name:

(18)

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

Yes

(19)

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

N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

Autumn Leaves, Inc.
d/b/a Hickory Street Place, Beacon Stree Place, 44th Street Place
December 31, 2012

Documentation - Section V, Line 7, Column 3:

Waste Removal	1,360
Pest Control	687
Security	<u>6,292</u>
	<u>8,339</u>

Documentation - Section V, Line 15, Column 3:

Workshop	173,746
Emergency Dental Care	2,934
Drugs & Medicine	<u>2,827</u>
	<u>179,507</u>

Documentation - Section V, Line 30, Column 7:

Depreciation - Related Party	12,903
Straight-line adjustment	<u>6,360</u>
	<u>19,263</u>

Reclassifications - Section V, Column 5:

	<u>From Line #</u>	<u>To Line #</u>	<u>Amount</u>
Employee Benefits (Staff Meals)	2	22	4,847

Page 7, Schedule VII, C, Related Parties
Column 5, Compensation Received from Other Homes

David Jacobus

Drew Corporation

d/b/a Moultrie County Community Center Decatur, Illinois	<u>26,000</u>
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Section XVII, Reconciliation of Income to Taxable Income:

Net Income (Loss) Per Books	16,367
Additions:	
Rounding	
Fines and Penalties	
Deductions:	
Rounding	<u>(1)</u>
Taxable Income	<u>16,366</u>

Section XX, General Information, Question 12:

Salary costs are allocated based upon actual hours worked.