

		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
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: 0047597

Facility Name: Jerseyville Manor

Address: 1251 North State Street Jerseyville 62052
Number City Zip Code

County: Jersey

Telephone Number: (618) 498-6441 Fax # (618) 498-9025

HFS ID Number:

Date of Initial License for Current Owners: 09/28/05

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) (3)

☐ 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: Ron Wilson Telephone Number: (309) 343-1550
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 10/1/11 to 9/30/12 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) (Date)

(Type or Print Name) Tina Calhoun

(Title) Director of Operations

Paid
Preparer

(Signed) See Preparation Report (Date)

(Print Name and Title) McGladrey LLP
117 E. Main St., Suite 210

(Firm Name & Address) P.O. Box 1070
Galesburg, IL 61401

(Telephone) (309) 342-1175 Fax # (309) 342-7816

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 Jerseyville Manor# 0047597 Report Period Beginning: 10/1/11 Ending: 9/30/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>160</u>	Skilled (SNF)	<u>160</u>	<u>58,560</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>160</u>	TOTALS	<u>160</u>	<u>58,560</u>	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	<u>24,668</u>	<u>13,253</u>	<u>6,619</u>	<u>44,540</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,668</u>	<u>13,253</u>	<u>6,619</u>	<u>44,540</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.06%

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)

None

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 10/01/05

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

YES ☒Date 9/28/05NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 160 and days of care provided 5,899Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 9/30/12Fiscal Year: 9/30/12

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

	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	252,512	23,694	5,890	282,096		282,096		282,096			1
2	Food Purchase		327,250		327,250		327,250	(1,174)	326,076			2
3	Housekeeping	159,107	53,894		213,001		213,001		213,001			3
4	Laundry	67,677	25,426		93,103		93,103		93,103			4
5	Heat and Other Utilities			156,756	156,756		156,756		156,756			5
6	Maintenance	64,142	31,402	53,380	148,924		148,924		148,924			6
7	Other (specify):*											7
8	TOTAL General Services	543,438	461,666	216,026	1,221,130		1,221,130	(1,174)	1,219,956			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,254,050	348,261	9,022	2,611,333		2,611,333		2,611,333			10
10a	Therapy			808,641	808,641		808,641		808,641			10a
11	Activities	84,872	2,805		87,677		87,677		87,677			11
12	Social Services	33,410			33,410		33,410		33,410			12
13	CNA Training			2,884	2,884		2,884		2,884			13
14	Program Transportation			643	643	6,058	6,701		6,701			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,372,332	351,066	835,590	3,558,988	6,058	3,565,046		3,565,046			16
	C. General Administration											
17	Administrative	152,329			152,329		152,329		152,329			17
18	Directors Fees							4,796	4,796			18
19	Professional Services			299,335	299,335		299,335	3,428	302,763			19
20	Dues, Fees, Subscriptions & Promotions			79,385	79,385		79,385	(67,613)	11,772			20
21	Clerical & General Office Expenses	71,654	34,393	40,069	146,116		146,116	766	146,882			21
22	Employee Benefits & Payroll Taxes			548,013	548,013		548,013		548,013			22
23	Inservice Training & Education			5,031	5,031		5,031		5,031			23
24	Travel and Seminar			240	240		240		240			24
25	Other Admin. Staff Transportation			12,115	12,115	(6,058)	6,057		6,057			25
26	Insurance-Prop.Liab.Malpractice			85,741	85,741		85,741	32,937	118,678			26
27	Other (specify):* See Att Sch V	68,732		16,440	85,172		85,172	(85,172)				27
28	TOTAL General Administration	292,715	34,393	1,086,369	1,413,477	(6,058)	1,407,419	(110,858)	1,296,561			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,208,485	847,125	2,137,985	6,193,595		6,193,595	(112,032)	6,081,563			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			92,922	92,922		92,922	418,213	511,135			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							532,086	532,086			32
33	Real Estate Taxes							121,680	121,680			33
34	Rent-Facility & Grounds			878,400	878,400		878,400	(878,400)				34
35	Rent-Equipment & Vehicles			11,904	11,904		11,904		11,904			35
36	Other (specify):* See Att Sch IV							3,294	3,294			36
37	TOTAL Ownership			983,226	983,226		983,226	196,873	1,180,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			27,037	27,037		27,037		27,037			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			446,947	446,947		446,947		446,947			42
43	Other (specify):* Outpatient Care			1,175	1,175		1,175		1,175			43
44	TOTAL Special Cost Centers			475,159	475,159		475,159		475,159			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,208,485	847,125	3,596,370	7,651,980		7,651,980	84,841	7,736,821			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,174)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(6,541)	V-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		V-21		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	(13,711)	V-27		24
25	Fund Raising, Advertising and Promotional	(67,664)	V-20		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(72,471)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,561)		\$	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)	233,012		34
35	Other- Attach Schedule See Att Sch III	13,390		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 246,402		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 84,841		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

Jerseyville Manor

Report Period Beginning: ID# 0047597

Ending: 10/1/11

9/30/12

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

Summary B

9/30/12

[illegible]

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
None	N/A	Unlimited Development, Inc (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34	Facility Rent	\$ 878,400	Jerseyville North State, LLC	N/A	\$ 1,111,412	\$ 233,012	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				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			\$ 878,400			\$ 1,111,412	\$ * 233,012	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	See Attached Schedule II & III								\$ 4,796	18-7	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	\$ 4,796		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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 Unlimited Development, Inc.
Street Address 285 S Farnham
City / State / Zip Code Galesburg, IL 61401
Phone Number (309) 343-1550
Fax Number (309) 343-2857

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2		See Att Sch II & III							13,390	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					\$	\$		13,390	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	Cambridge Realty Capital LTD. Of Illinois						\$	\$			\$	1	
2			X	Facility purchase	\$17,694.29	5/1/2012	4,173,100	4,157,006	03/01/2046	3.5500	538,627	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Miscellaneous		X									6	
7	Less Interest Income		X								(6,541)	7	
8												8	
9	TOTAL Facility Related				\$17,694.29		\$ 4,173,100	\$ 4,157,006			\$ 532,086	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,173,100	\$ 4,157,006			\$ 532,086	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,717 Line # 26

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	83,585	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.)			\$	116,445	2
3. Under or (over) accrual (line 2 minus line 1).			\$	32,860	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	88,820	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.			\$	121,680	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007 50,415 8	FOR BHF USE ONLY		
		2008 53,137 9			
		2009 111,236 10	13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
		2010 113,784 11	14	PLUS APPEAL COST FROM LINE 5 \$	14
		2011 116,445 12	15	LESS REFUND FROM LINE 6 \$	15
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained. Amount accrued includes estimated taxes for 9 months based on fiscal year end.			16	AMOUNT TO USE FOR RATE CALCULATION \$	16
Estimate is based on prior year tax bill. Taxes paid during year represents the entire 2011 tax bill.					

- 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
Jerseyville Manor

COUNTY
Jersey

FACILITY IDPH LICENSE NUMBER
0047597

CONTACT PERSON REGARDING THIS REPORT
Ron Wilson

TELEPHONE
(309) 343-1550
FAX #:
(309) 343-2857

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. 04-127-014-00	S17 T8 R11 UNPLATTED	\$ 116,123.40	\$ 116,123.40
2.	PARCELS PT SE 1/4 (TRACT	\$	\$
3.	1 - SURVEY IN PLAT CAB	\$	\$
4.	1/54B)	\$	\$
5.		\$	\$
6. 04-127-014-50	S17 T8 R11 TRACT IN SE 1/4	\$ 321.28	\$ 321.28
7.	(PT TRACT 2 SURVEY	\$	\$
8.	PC 1/54B)	\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 116,444.68	\$ 116,444.68

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: 55,306

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	3.5 Acres	2005	\$ 160,000	1
2	Facility Addition	.88 Acres	2008	14,025	2
3	TOTALS	#VALUE!		\$ 174,025	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	92		2005		\$ 4,578,867	\$ 114,470	40	\$ 114,470	\$	\$ 810,839	4
5	68		2008		4,926,175	197,047	25	197,047		788,188	5
6											6
7											7
8											8
	Improvement Type**										
9	Attic Insulation		2005		5,952	397	15	397		2,778	9
10	Parking Lot Lighting		2006		5,355	357	15	357		2,321	10
11	Furnace		2008		2,516	167	15	167		726	11
12	Wall Paper/Paint Dining/Kitchen/Beauty Shop		2008		10,556	2,111	5	2,111		8,621	12
13	Floor Scrubber		2008		8,066	1,614	5	1,614		6,722	13
14	Electric Sign		2008		44,743	4,475	10	4,475		19,389	14
15	Parking Lot		2008		244,322	30,539	8	30,539		122,160	15
16	Retention Pond		2008		37,026	1,850	20	1,850		7,404	16
17	Sidewalks		2008		64,009	4,266	15	4,266		17,068	17
18	Landscaping		2008		39,235	3,922	10	3,922		15,693	18
19	Fence		2008		8,442	562	15	562		2,250	19
20	Electric Install, Recliner Wheelchairs, Baskets		2008		37,076	2,852	13	2,852		11,170	20
21	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over		2008		15,149	1,515	10	1,515		5,807	21
22	Roof		2008		116,316	11,631	10	11,631		45,557	22
23	Paint & Wallpaper		2008		6,491	1,298	5	1,298		5,193	23
24	Paint & Wallpaper		2008		7,295	1,459	5	1,459		5,836	24
25	Fence		2008		2,655	331	8	331		1,271	25
26	Window Decorations		2009		70,822	14,164	5	14,164		51,936	26
27	Duct Work		2009		15,739	1,574	10	1,574		5,640	27
28	Veranda		2009		2,987	199	15	199		714	28
29	Outside Lights (Buildings & Parking Lot)		2009		44,204	2,947	15	2,947		10,314	29
30	Jerseyville Parking Lot - Asphalt		2009		131,323	16,415	8	16,415		49,246	30
31	Water heater		2010		4,760	476	10	476		952	31
32	Generator		2011		3,825	764	5	764		955	32
33	Water heater		2011		4,407	441	10	441		478	33
34	Lobby Remodel (Contracted Total)		2011		31,490	2,624	12	2,624		5,248	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,469,803	\$ 420,467		\$ 420,467	\$	\$ 2,004,476	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	\$843,760	\$90,331	\$90,331		5-15 yrs	\$440,067	71
72	Current Year Purchases	3,020	337	337		3 yrs	337	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$846,780	\$90,668	\$90,668			\$440,404	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 Care	2003 GMC G3500 Van	2006	\$29,848				4 yrs	\$29,848	76
77										77
78										78
79										79
80	TOTALS			\$29,848					\$29,848	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,520,456	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$511,135	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$511,135	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,474,728	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	2005 Ford E350 - 2005	\$47,110		\$47,110	86
87	2006 Toyota Corolla - 2006	15,288		15,288	87
88					88
89					89
90					90
91	TOTALS	\$62,398		\$62,398	91

G. Construction-in-Progress

	Description	Cost	
92	Shower Room Remodel	\$135,514	92
93			93
94			94
95		\$135,514	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:Jerseyville North State, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			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 leaseN/A.
9. Option to Buy:☐ YES☐ NOTerms: N/A*

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: \$11,904Description: See Attached Schedule XII
(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 EndingAnnual Rent

12. /2013\$ N/A
13. /2014\$ N/A
14. /2015\$ N/A

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

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 83,447	\$ 582,611	1
2	Cash-Patient Deposits	17,660	17,660	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,742)	1,548,500	1,548,500	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,326	131,394	6
7	Other Prepaid Expenses	845	845	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	3,714,565	3,742,900	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,486,343	\$ 6,023,910	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		174,025	13
14	Buildings, at Historical Cost		9,898,076	14
15	Leasehold Improvements, at Historical Cost	571,727	571,727	15
16	Equipment, at Historical Cost	283,500	939,026	16
17	Accumulated Depreciation (book methods)	(438,501)	(2,537,126)	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): See Att Sch VII	135,514	401,545	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 552,240	\$ 9,447,273	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,038,583	\$ 15,471,183	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 113,586	\$ 148,183	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,660	17,660	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,303	75,303	30
31	Accrued Taxes Payable (excluding real estate taxes)	117,361	117,361	31
32	Accrued Real Estate Taxes(Sch.IX-B)		88,820	32
33	Accrued Interest Payable		356,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		497,822	36
37	Current portion of long term payable		65,822	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 323,910	\$ 1,367,585	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,738,601	39
40	Mortgage Payable		4,091,184	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	21,000	21,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 21,000	\$ 9,850,785	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 344,910	\$ 11,218,370	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,693,673	\$ 4,252,813	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,038,583	\$ 15,471,183	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,752,002	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,752,002	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	941,671	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)	\$ 941,671	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)	\$ 5,693,673	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Jerseyville Manor# 0047597Report Period Beginning: 10/1/11Ending: 9/30/12

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	\$ 8,120,700	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,120,700	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	453,944	6
7	Oxygen	480	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 454,424	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	1,430	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,174	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	26	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,630	23
	D. Non-Operating Revenue		
24	Contributions	615	24
25	Interest and Other Investment Income***	6,541	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,156	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schdule X	8,741	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,741	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,593,651	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,221,130	31
32	Health Care	3,558,988	32
33	General Administration	1,413,477	33
	B. Capital Expense		
34	Ownership	983,226	34
	C. Ancillary Expense		
35	Special Cost Centers	28,212	35
36	Provider Participation Fee	446,947	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,651,980	40
41	Income before Income Taxes (line 30 minus line 40)**	941,671	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 941,671	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,228,504	44
45	Private Pay - Net Inpatient Revenue	2,057,896	45
46	Medicare - Net Inpatient Revenue	2,750,313	46
47	Other-(specify)		47
48	Other-(specify) <u>See Att Sch XI</u>	83,987	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,120,700	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	2,009	2,137	\$ 74,055	\$ 34.65	1
2	Assistant Director of Nursing	2,150	2,287	54,898	24.00	2
3	Registered Nurses	14,338	15,254	326,273	21.39	3
4	Licensed Practical Nurses	23,633	25,141	431,175	17.15	4
5	CNAs & Orderlies	116,257	123,257	1,277,595	10.37	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	8,100	8,617	84,872	9.85	10
11	Social Service Workers	3,049	3,244	33,410	10.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,478	27,105	252,512	9.32	15
16	Dishwashers					16
17	Maintenance Workers	4,186	4,453	64,142	14.40	17
18	Housekeepers	16,231	17,267	159,107	9.21	18
19	Laundry	7,502	7,981	67,677	8.48	19
20	Administrator	1,956	2,080	114,621	55.11	20
21	Assistant Administrator	1,966	2,091	37,708	18.03	21
22	Other Administrative	3,182	3,385	68,732	20.30	22
23	Office Manager					23
24	Clerical	5,239	5,573	71,654	12.86	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	1,968	2,093	24,305	11.61	31
32	Other Health Care(specify)	3,451	3,671	65,749	17.91	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	240,695	255,636	\$ 3,208,485 *	\$ 12.55	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	***	\$ 5,890	1-3	35
36	Medical Director	***	14,400	9-3	36
37	Medical Records Consultant	***	535	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	8,487	10-3	39
40	Physical Therapy Consultant	***	337,487	10a-3	40
41	Occupational Therapy Consultant	***	333,407	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	137,747	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***	0	10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		\$ 837,953		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Dana Bainter	Administrator	None	\$ 114,621	Workers' Compensation Insurance		\$ 130,806	IDPH License Fee		\$ 740
Mary Mosby	Asst Admin	None	37,708	Unemployment Compensation Insurance		8,082	Advertising: Employee Recruitment		740
				FICA Taxes		237,607	Health Care Worker Background Check		
				Employee Health Insurance		150,052	(Indicate # of checks performed 61)		1,710
				Employee Meals			Patient Background Checks 129		1,290
				Illinois Municipal Retirement Fund (IMRF)*			Advertising - Promotion		67,664
				401 (k)		16,968	Subscriptions		1,459
				Other Employee Benefits		4,498	IHCA Dues		5,993
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Other Licenses & Fees		529
							Indirect Costs - See Att Sch III		51
B. Administrative - Other							Less: Public Relations Expense		()
Description							Non-allowable advertising		(67,664)
							Yellow page advertising		()
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,772
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 548,013			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount	Line #			Amount		
RFMS, Inc	Administrative Services		\$ 171,600				\$		
McGladrey LLP	Accounting Services		8,000						
LTC Support Services, LLC	Support Services		115,920						
Singleton Law Firm PC	Legal Services		66						
Polsinelli Shughart	Legal Services		2,739						
Norbert J. Goetten	Collection Services		1,010						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			\$		

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

XX. GENERAL INFORMATION:

(1)

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

No

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

See Page 21 section F

(3)

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

Yes - IHCA dues

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

Yes

(4)

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

No

If YES, what is the capacity?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

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

3 yrs

(6)

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

\$

41,555

Line

10

(7)

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

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(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.

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

446,947

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

None

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

1,174

(16)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

N/A

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

None

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.

\$

N/A

(17)

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

Yes

Firm Name:

McGladrey LLP

(18)

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

Yes

(19)

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

N/A

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