

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0034223 Facility Name: Lawrence Place Address: 715 South Washington Street Lincoln 62656 County: Logan Telephone Number: (217) 732-3625 Fax #: (217) 735-4437 HFS ID Number: Date of Initial License for Current Owners: 09/16/88 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
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In the event there are further questions about this report, please contact:

Name: Ron Wilson Telephone Number: (309) 343-1550

Email Address:

Facility Name & ID Number Lawrence Place# 0034223 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 beds _____

	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	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,787			5,787	13
14	TOTALS	5,787			5,787	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.82%

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

52 (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 ☒Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/16/88

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

YES ☒Date 03/27/90NO ☐

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

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

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.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	38,695	7,471	1,026	47,192		47,192		47,192			1
2	Food Purchase		51,819		51,819		51,819		51,819			2
3	Housekeeping	19,376	3,765		23,141		23,141		23,141			3
4	Laundry		2,827		2,827		2,827		2,827			4
5	Heat and Other Utilities			13,082	13,082		13,082		13,082			5
6	Maintenance	9,080	5,832	5,614	20,526		20,526		20,526			6
7	Other (specify):*											7
8	TOTAL General Services	67,151	71,714	19,722	158,587		158,587		158,587			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	184,361	4,716	3,711	192,788		192,788		192,788			10
10a	Therapy											10a
11	Activities		565	448	1,013		1,013		1,013			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			5,586	5,586		5,586		5,586			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	184,361	5,281	14,245	203,887		203,887		203,887			16
	C. General Administration											
17	Administrative	14,067			14,067		14,067		14,067			17
18	Directors Fees							1,036	1,036			18
19	Professional Services			70,658	70,658		70,658	3,188	73,846			19
20	Dues, Fees, Subscriptions & Promotions			832	832		832	722	1,554			20
21	Clerical & General Office Expenses	18,863	2,914	2,525	24,302		24,302	651	24,953			21
22	Employee Benefits & Payroll Taxes			62,116	62,116		62,116	129	62,245			22
23	Inservice Training & Education			2,693	2,693		2,693		2,693			23
24	Travel and Seminar			348	348		348		348			24
25	Other Admin. Staff Transportation			719	719		719		719			25
26	Insurance-Prop.Liab.Malpractice			10,214	10,214		10,214	50	10,264			26
27	Other (specify):*											27
28	TOTAL General Administration	32,930	2,914	150,105	185,949		185,949	5,776	191,725			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	284,442	79,909	184,072	548,423		548,423	5,776	554,199			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			17,720	17,720		17,720	(421)	17,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			17,720	17,720		17,720	(421)	17,299			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			40,105	40,105		40,105		40,105			42
43	Other (specify):* Non-allowable Costs			472	472		472	(472)				43
44	TOTAL Special Cost Centers			40,577	40,577		40,577	(472)	40,105			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	284,442	79,909	242,369	606,720		606,720	4,883	611,603			45

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

Facility Name & ID Number Lawrence Place # 0034223 Report Period Beginning: 10/1/11 Ending: 9/30/12
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(421)	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	(308)	43		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	(164)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (893)		\$	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)	5,776		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 5,776		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 4,883		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lawrence Place

ID#

0034223

Report Period Beginning:

10/1/11

Ending:

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 Lawrence Place # 0034223 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	1,036	0	0	0	0	0	0	0	0	0	1,036	18
19	Professional Services	0	3,188	0	0	0	0	0	0	0	0	0	3,188	19
20	Fees, Subscriptions & Promotions	0	722	0	0	0	0	0	0	0	0	0	722	20
21	Clerical & General Office Expenses	0	651	0	0	0	0	0	0	0	0	0	651	21
22	Employee Benefits & Payroll Taxes	0	129	0	0	0	0	0	0	0	0	0	129	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	50	0	0	0	0	0	0	0	0	0	50	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	5,776	0	0	0	0	0	0	0	0	0	5,776	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	5,776	0	0	0	0	0	0	0	0	0	5,776	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	Community Living Options, Inc. (CLO)		See Attached Schedule I		
		Unlimited Development, Inc. (UDI)				
		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:	
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	18	Director Fees	\$	Community Living Options, Inc.	0.00%	\$ 1,036	\$ 1,036	1
2	V	19	Legal Fees		Community Living Options, Inc.	0.00%	324	324	2
3	V	19	Professional Fees		Community Living Options, Inc.	0.00%	2,864	2,864	3
4	V	20	Dues, Licenses and Subs		Community Living Options, Inc.	0.00%	722	722	4
5	V	21	Clerical & General Expenses		Community Living Options, Inc.	0.00%	651	651	5
6	V	22	Employee Benefit & P/R Taxes		Community Living Options, Inc.	0.00%	129	129	6
7	V	26	Property Insurance		Community Living Options, Inc.	0.00%	50	50	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 5,776	\$ * 5,776	14

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II								\$ 1,036	L18, C7	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	\$ 1,036		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

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

X

NO

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

Name of Related Organization

Community Living Options, Inc.

Street Address

285 S Farnham

City / State / Zip Code

Galesburg, IL 61401

Phone Number

(309) 343-1550

Fax Number

(309) 343-2857

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	Director Fees	Bed Days Available	199,104	34	\$ 35,224	\$	5,856	\$ 1,036	1
2	19	Legal Fees	Bed Days Available	199,104	34	11,012		5,856	324	2
3	19	Professional Fees	Bed Days Available	199,104	34	97,388		5,856	2,864	3
4	20	Dues, Licenses and Subs	Bed Days Available	199,104	34	24,543		5,856	722	4
5	21	Clerical & General Expenses	Bed Days Available	199,104	34	22,123		5,856	651	5
6	22	Employee Benefit & P/R Taxes	Bed Days Available	199,104	34	4,397		5,856	129	6
7	26	Property Insurance	Bed Days Available	199,104	34	1,702		5,856	50	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					\$ 196,389	\$		\$ 5,776	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	N/A	8	
		2008	N/A	9	
		2009	N/A	10	
		2010	N/A	11	
		2011	N/A	12	
This facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for the real estate tax is required.				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Lawrence Place

COUNTY
Logan

FACILITY IDPH LICENSE NUMBER
0034223

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()
FAX #: ()

A.
Summary of Real Estate Tax Cost

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

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	N/A		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$	\$

B.
Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,900 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: 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	Facility	68,328	1990	\$ 22,692	1
2					2
3	TOTALS	68,328		\$ 22,692	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1990	1988	\$ 412,308	\$ 14,165	30	\$ 13,744	\$ (421)	\$ 310,407
5										
6										
7										
8										
	Improvement Type**									
9	Garage, Parking Lot, Sidewalks and Landscaping			1988	30,000		15			30,000
10	Shower			2004	2,325	55	7	55		2,325
11	Water Heaters, Carpet/Vinyl and Shower			2005	8,129	779	7-10yrs	779		6,759
12	Vanity Sink/Drawer base/Sink/Mirror			2007	3,169	212	15	212		1,057
13	Roof			2008	11,702	1,170	10	1,170		5,071
14	Fire Alarm Panel/Air Pressure Switches			2009	4,150	415	10	415		1,487
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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)		\$ 471,783	\$ 16,796		\$ 16,375	\$ (421)	\$ 357,106	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	\$56,182	\$924	\$924		3-15 yrs	\$46,822	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home office allocation							74
75	TOTALS	\$56,182	\$924	\$924			\$46,822	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	2001 Ford E350 Van	2002	\$18,301				4 yrs	\$18,301	76
77										77
78										78
79										79
80	TOTALS			\$18,301					\$18,301	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)	\$568,958	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$17,720	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$17,299	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(421)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$422,229	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A facility owned
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 N/A.
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ N/A Description: ☐ YES ☐ NO
(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	\$ 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	N/A	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,008,023	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,008,023	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,124	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)	\$ 61,124	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)	\$ 2,069,147	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lawrence Place# 0034223Report Period Beginning: 10/1/11

Ending:

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	2	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 666,856	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 666,856	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	635	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 635	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	353	27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 353	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 667,844	30

	1	2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	158,587	31
32	Health Care	203,887	32
33	General Administration	185,949	33
	B. Capital Expense		
34	Ownership	17,720	34
	C. Ancillary Expense		
35	Special Cost Centers	472	35
36	Provider Participation Fee	40,105	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 606,720	40
41	Income before Income Taxes (line 30 minus line 40)**	61,124	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 61,124	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 666,856	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 666,856	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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	562	604	13,287	22.00	4
5	CNAs & Orderlies	11,998	13,041	142,798	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,528	3,794	38,695	10.20	15
16	Dishwashers					16
17	Maintenance Workers	603	649	9,080	13.99	17
18	Housekeepers	1,646	1,769	19,376	10.95	18
19	Laundry					19
20	Administrator	523	563	14,067	24.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,307	1,406	18,863	13.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,541	1,656	28,276	17.07	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)	21,708	23,482	\$ 284,442 *	\$ 12.11	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	Monthly	\$ 1,026	L1, C3	35
36	Medical Director	Monthly	4,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	888	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychological Cons	Monthly	1,020	L10, C3	46
47	Dental Consultant	Monthly	1,803	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,237		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID NumberLawrence Place# 0034223Report Period Beginning: 10/1/11Ending: 9/30/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Adam Tabor	Administrator	0	\$ 14,067
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 14,067

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	\$ 33,990
McGladrey & Pullen, LLP	Accounting Services	9,460
LTC Support Services, LLC	Support Services	23,610
Polsinelli Shughart PC	Legal Services	3,598
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 70,658

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 10,578
Unemployment Compensation Insurance	
FICA Taxes	19,439
Employee Health Insurance	27,193
Employee Meals	1,500
Illinois Municipal Retirement Fund (IMRF)*	
401k	2,235
Other Employee Benefits	1,171
Indirect costs	129
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	38
Health Care Worker Background Check (Indicate # of checks performed 6)	59
Patient Background Checks	0
Subscriptions	195
IHCA Dues	530
Other Licenses & Fees	10
Indirect costs	722
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	348
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 348

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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

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

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Yes

If YES, give association name and amount.

530 IHCA
- (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?

N/A
- (6)

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

\$

796

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.
- (11)

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

\$

40,105

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.

\$

1,500

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

N/A
- (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 & Pullen, 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.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	38,695	7,471	1,026	47,192	0	47,192	0	47,192
2. Food Purchase	0	51,819	0	51,819	0	51,819	0	51,819
3. Housekeeping	19,376	3,765	0	23,141	0	23,141	0	23,141
4. Laundry	0	2,827	0	2,827	0	2,827	0	2,827
5. Heat and Other Utilities	0	0	13,082	13,082	0	13,082	0	13,082
6. Maintenance	9,080	5,832	5,614	20,526	0	20,526	0	20,526
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	67,151	71,714	19,722	158,587	0	158,587	0	158,587
9. Medical Director	0	0	4,500	4,500	0	4,500	0	4,500
10. Nursing & Medical Records	184,361	4,716	3,711	192,788	0	192,788	0	192,788
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	0	565	448	1,013	0	1,013	0	1,013
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	5,586	5,586	0	5,586	0	5,586
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	184,361	5,281	14,245	203,887	0	203,887	0	203,887
17. Administrative	14,067	0	0	14,067	0	14,067	0	14,067
18. Directors Fees	0	0	0	0	0	0	1,036	1,036
19. Professional Services	0	0	70,658	70,658	0	70,658	3,188	73,846
20. Fees, Subscriptions & Promotion	0	0	832	832	0	832	722	1,554
21. Clerical & General Office	18,863	2,914	2,525	24,302	0	24,302	651	24,953
22. Employee Benefits & Payroll	0	0	62,116	62,116	0	62,116	129	62,245
23. Inservice Training & Education	0	0	2,693	2,693	0	2,693	0	2,693
24. Travel and Seminar	0	0	348	348	0	348	0	348
25. Other Admin. Staff Trans	0	0	719	719	0	719	0	719
26. Insurance-Prop.Liab.Malpractice	0	0	10,214	10,214	0	10,214	50	10,264
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	32,930	2,914	150,105	185,949	0	185,949	5,776	191,725
29. Total General Administrative	284,442	79,909	184,072	548,423	0	548,423	5,776	554,199
30. Depreciation	0	0	17,720	17,720	0	17,720	-421	17,299
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	17,720	17,720	0	17,720	-421	17,299
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	40,105	40,105	0	40,105	0	40,105
43. Other (specify):*	0	0	472	472	0	472	-472	0
44. Total Special Cost Ce	0	0	40,577	40,577	0	40,577	-472	40,105
45. Grand Total	284,442	79,909	242,369	606,720	0	606,720	4,883	611,603

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	316,503	316,503
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	15,393	15,393
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	1,620,417	1,620,417
10. Total current assets	1,952,313	1,952,313
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	10,000	22,692
14. Buildings, at Historical Cost	484,475	471,783
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	74,483	74,483
17. Accumulated Depreciation (book methods)	-431,753	-422,229
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	137,205	146,729
25. Total Assets	2,089,518	2,099,042
CURRENT LIABILITIES		
26. Accounts Payable	7,661	7,661
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	11,971	11,971
31. Accrued Taxes Payable	739	739
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	20,371	20,371
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	20,371	20,371
47.Total Equity	2,069,147	2,078,671
48.Total Liabilities and Equity	2,089,518	2,099,042

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	666,856
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	666,856
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	635
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	635
27. Other Revenue (specify):	353
28. Other Revenue (specify):	0
Subtotal - Other Revenue	353
30. Total Revenue	667,844
31. General Services	158,587
32. Health Care	203,887
33. General Administration	185,949
34. Ownership	17,720

35. Special Cost Centers	472
35. Provider Participation Fee	40,105
37. Other	0
40. Total Expenses	606,720
41. Income Before Income Taxes	61,124
42. Income Taxes	0
43. Net Income or Loss for the Year	61,124