

		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: <u>0018044</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>PRAIRIEVIEW LUTHERAN HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>PO BOX 4</u> <u>DANFORTH</u> <u>60930</u>																									
Number City Zip Code																									
County: <u>IROQUOIS</u>																									
Telephone Number: <u>815-269-2970</u> Fax # <u>815-269-2930</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ATTACHED COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>BRUCE FOX</u> <u>CPA</u></td></tr><tr><td>(Firm Name & Address) <u>FOX CPA GROUP, LTD</u> <u>204 E CHERRY STREET, SUITE 300, WATSEKA, IL 60970</u></td></tr><tr><td>(Telephone) <u>815-432-3126</u> Fax # <u>815-432-6061</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ATTACHED COMPILATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>BRUCE FOX</u> <u>CPA</u>	(Firm Name & Address) <u>FOX CPA GROUP, LTD</u> <u>204 E CHERRY STREET, SUITE 300, WATSEKA, IL 60970</u>	(Telephone) <u>815-432-3126</u> Fax # <u>815-432-6061</u>												
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	(Telephone) <u>815-432-3126</u> Fax # <u>815-432-6061</u>																								
Date of Initial License for Current Owners: <u>02/14/74</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 C (3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 C (3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Jo Marie Silver</u> Telephone Number: <u>815-269-2970</u> Email Address: _____																									
SEE ACCOUNTANTS' COMPILATION REPORT																									

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044 Report Period Beginning: 1/1/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	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>90</u>	Skilled (SNF)	<u>90</u>	<u>32,940</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>90</u>	TOTALS	<u>90</u>	<u>32,940</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,780</u>	<u>22,440</u>	<u>1,819</u>	<u>30,039</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,780</u>	<u>22,440</u>	<u>1,819</u>	<u>30,039</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.19%

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)
OUTPATIENT THERAPY

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

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

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 02/14/74

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 1,819

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number		PRAIRIEVIEW LUTHERAN HOME				#	0018044	Report Period Beginning:		1/1/12	Ending: 12/31/12	
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	393,909	29,395	7,844	431,148		431,148		431,148			1
2	Food Purchase		251,348		251,348	(15,422)	235,926		235,926			2
3	Housekeeping	158,152	46,599		204,751		204,751		204,751			3
4	Laundry	90,567	13,740		104,307		104,307		104,307			4
5	Heat and Other Utilities			98,992	98,992		98,992		98,992			5
6	Maintenance	119,113	9,419	45,001	173,533		173,533		173,533			6
7	Other (specify):* MEDICAL WASTE					15,954	15,954		15,954			7
8	TOTAL General Services	761,741	350,501	151,837	1,264,079	532	1,264,611		1,264,611			8
	B. Health Care and Programs											
9	Medical Director					4,800	4,800		4,800			9
10	Nursing and Medical Records	2,365,942	273,390	44,205	2,683,537	(21,666)	2,661,871	(17,577)	2,644,294			10
10a	Therapy			488,026	488,026	474	488,500	(57,617)	430,883			10a
11	Activities	205,732	3,283	4,220	213,235		213,235		213,235			11
12	Social Services	48,974	121	1,653	50,748		50,748		50,748			12
13	CNA Training											13
14	Program Transportation					595	595		595			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,620,648	276,794	538,104	3,435,546	(15,797)	3,419,749	(75,194)	3,344,555			16
	C. General Administration											
17	Administrative	73,083			73,083		73,083		73,083			17
18	Directors Fees											18
19	Professional Services			94,590	94,590		94,590	(2,106)	92,484			19
20	Dues, Fees, Subscriptions & Promotions			50,198	50,198	2,504	52,702	(27,065)	25,637			20
21	Clerical & General Office Expenses	266,575	24,749	129,060	420,384	(5,320)	415,064	(12,114)	402,950			21
22	Employee Benefits & Payroll Taxes			1,088,966	1,088,966	18,676	1,107,642		1,107,642			22
23	Inservice Training & Education					2,212	2,212		2,212			23
24	Travel and Seminar			13,841	13,841	(2,807)	11,034	(148)	10,886			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,516	36,516		36,516		36,516			26
27	Other (specify):*											27
28	TOTAL General Administration	339,658	24,749	1,413,171	1,777,578	15,265	1,792,843	(41,433)	1,751,410			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,722,047	652,044	2,103,112	6,477,203		6,477,203	(116,627)	6,360,576			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			183,911	183,911		183,911		183,911			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			183,911	183,911		183,911		183,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			27,985	27,985		27,985		27,985			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			350,016	350,016		350,016		350,016			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			378,001	378,001		378,001		378,001			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,722,047	652,044	2,665,024	7,039,115		7,039,115	(116,627)	6,922,488			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(57,617)	10A		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,577)	10		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,125)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,106)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,989)	21		24
25	Fund Raising, Advertising and Promotional	(25,977)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,088)	20		28
29	Other-Attach Schedule TRAVEL	(148)	24		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,627)		\$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (116,627)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops		X			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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: ID# 0018044

Ending: 1/1/12

12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[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
N/A						

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

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	N/A					\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.		\$	N/A	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).		\$	#VALUE!	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.		\$	#VALUE!	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>PRAIRIEVIEW LUTHERAN HOME</u>	COUNTY	<u>IROQUOIS</u>
---------------	----------------------------------	--------	-----------------

FACILITY IDPH LICENSE NUMBER 0018044

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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: 49,200

B. General Construction Type: Exterior BRICKFrame STEEL & BRICKNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 1,189

2. Number of Years Over Which it is Being Amortized: 30

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	BLDG/GROUNDS	304,920	1971	\$ 9,115	1
2					2
3	TOTALS	304,920		\$ 9,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60			1973	\$ 649,963	\$ 16,249	40	\$ 16,249	\$	537,991	4
5				1995	1,011,406	25,285	40	25,285		445,325	5
6	32			1996	1,834,874	45,872	40	45,872		718,664	6
7											7
8											8
	Improvement Type**										
9	FULLY DEPRECIATED				680,123					680,123	9
10	PRIOR TO 2009				3,303	132	25	132		2,876	10
11	PRIOR TO 2009				379,942	18,997	20	18,997		244,290	11
12	PRIOR TO 2009				72,742	4,850	15	4,850		29,043	12
13	PRIOR TO 2009				12,666	1,267	10	1,267		8,466	13
14	PRIOR TO 2009				83,879	2,098	40	2,098		8,776	14
15	PRIOR TO 2009				412,482	14,130	VARIOUS	14,130		268,401	15
16	TUB/SHOWER ROOM (CONTRACTED TOTAL)			2009	153,707	3,843	40	3,843		11,849	16
17	FIRE ALARM SYSTEM			2009	16,500	413	40	413		1,548	17
18	SPA TUB			2009	17,472	437	40	437		1,457	18
19	WINDOW SASHES			2009	1,381	138	40	138		472	19
20	ROOF TOP COMPRESSOR			2009	2,290	229	10	229		744	20
21	NEW ASPHALT			2009	7,780	389	20	389		1,329	21
22	SWITCH ASSEMBLIES FOR KOHLER GENE			2010	1,066	27	40	27		72	22
23	BATHROOM TILE			2010	680	17	40	17		45	23
24	NEW ROOF			2010	250,056	6,251	40	6,251		15,107	24
25	NEW FRONT SLOPED ROOF			2010	2,820	71	40	71		171	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,595,132	\$ 140,695		\$ 140,695	\$	\$ 2,976,749	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 527,804	\$ 34,250	\$ 34,250	\$	10	\$ 428,510	71
72	Current Year Purchases	27,302	732	732		10	732	72
73	Fully Depreciated Assets	387,306					387,306	73
74								74
75	TOTALS	\$ 942,412	\$ 34,982	\$ 34,982	\$		\$ 816,548	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	RES TRANSPORTATION	2010 FORD ELKHART	2010	\$ 45,949	\$ 4,595	\$ 4,595	\$	10	\$ 11,870
77	RES TRANSPORTATION	2007 FORD CONV VAN	2010	36,393	3,639	3,639		10	7,885
78									
79									
80	TOTALS			\$ 82,342	\$ 8,234	\$ 8,234	\$		\$ 19,755

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 6,629,001
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 183,911
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 183,911
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 3,813,052

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	LAND DONATED TO BE USED	\$ 35,540	\$	\$
87	FOR EXPANSION			
88				
89				
90				
91	TOTALS	\$ 35,540	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	ARCHITECT FEES	\$ 40,519
93		
94		
95		\$ 40,519

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	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	\$	2,532	\$ 187,162	\$	2,532	\$ 187,162	1
2	Licensed Speech and Language Development Therapist		hrs		319	22,308		319	22,308	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,285	236,087	474	3,285	236,561	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
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	6,136	\$ 445,557	\$ 474	6,136	\$ 446,031	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 181,219	\$	1
2	Cash-Patient Deposits	15,401		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,795)	1,028,534		3
4	Supply Inventory (priced at COST)	35,839		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,553		6
7	Other Prepaid Expenses	12,161		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM OTHER FUNDS	36,011		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,337,718	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,655		13
14	Buildings, at Historical Cost	5,064,676		14
15	Leasehold Improvements, at Historical Cost	269,080		15
16	Equipment, at Historical Cost	1,286,130		16
17	Accumulated Depreciation (book methods)	(3,813,052)		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): CONSTRUCTION IN PROG	40,519		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,892,008	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,229,726	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 485,826	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,231		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,724		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED REVENUE	421,326		36
37	OTHER ACCRUED EXPENSES	28,673		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,203,780	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,203,780	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,025,946	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,229,726	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,222,777	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,222,777	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(474,297)	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)	\$ (474,297)	17
	B. Transfers (Itemize):		
18	TRANSFERS FROM FOUNDATION	277,466	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 277,466	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,025,946	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,211,725	1
2	Discounts and Allowances for all Levels	(418,010)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,793,715	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	70,948	5
6	Therapy	597,046	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 667,994	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	25,987	13
14	Non-Patient Meals	28,162	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)	\$ 54,149	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	454	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 454	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SIU AND OTHER INCOME	27,662	28
28a	REIMBURSEMENTS	23,245	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 50,907	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,567,219	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,264,079	31
32	Health Care	3,435,546	32
33	General Administration	1,777,578	33
	B. Capital Expense		
34	Ownership	183,911	34
	C. Ancillary Expense		
35	Special Cost Centers	27,985	35
36	Provider Participation Fee	350,016	36
	D. Other Expenses (specify):		
37	LOSS ON ASSET DISPOSAL	2,401	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,041,516	40
41	Income before Income Taxes (line 30 minus line 40)**	(474,297)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (474,297)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 775,596	44
45	Private Pay - Net Inpatient Revenue	4,515,795	45
46	Medicare - Net Inpatient Revenue	502,324	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,793,715	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,840	2,080	\$ 66,912	\$ 32.17	1
2	Assistant Director of Nursing	3,648	4,020	111,683	27.78	2
3	Registered Nurses	17,700	19,403	443,815	22.87	3
4	Licensed Practical Nurses	25,261	27,128	558,653	20.59	4
5	CNAs & Orderlies	93,427	101,743	1,143,859	11.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	697	752	12,069	16.05	8
9	Activity Director	1,620	1,778	28,960	16.29	9
10	Activity Assistants	17,697	17,991	180,541	10.04	10
11	Social Service Workers	1,800	2,080	37,704	18.13	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	41,613	20.01	13
14	Head Cook	7,104	6,582	84,024	12.77	14
15	Cook Helpers/Assistants	35,479	29,969	268,272	8.95	15
16	Dishwashers					16
17	Maintenance Workers	5,453	5,745	119,113	20.73	17
18	Housekeepers	13,840	15,084	158,152	10.48	18
19	Laundry	7,946	8,737	90,567	10.37	19
20	Administrator	1,840	1,664	73,083	43.92	20
21	Assistant Administrator					21
22	Other Administrative	7,392	8,304	164,320	19.79	22
23	Office Manager					23
24	Clerical	8,812	9,440	128,093	13.57	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	869	880	10,614	12.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	254,265	265,460	\$ 3,722,047 *	\$ 14.02	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	143	\$ 7,844	1-3	35
36	Medical Director	192	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	123	5,752	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,764	11-3	44
45	Social Service Consultant	26	1,653	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	510	\$ 21,813		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		PRAIRIEVIEW LUTHERAN HOME		STATE OF ILLINOIS		Report Period Beginning:		1/1/12		Page 21		Ending:		12/31/12		
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						
KAREN SIPPEL		ADMINISTRATOR		\$ 73,083	Workers' Compensation Insurance		\$ 183,932	IDPH License Fee		\$ 5,972						
					Unemployment Compensation Insurance		47,165	Advertising: Employee Recruitment		3,654						
					FICA Taxes		276,887	Health Care Worker Background Check								
					Employee Health Insurance		514,241	(Indicate # of checks performed 94)		940						
					Employee Meals		20,660	Patient Background Checks		53	1,564					
					Illinois Municipal Retirement Fund (IMRF)*			VIEWS		10,125						
					MEDICAL REIMBURSEMENT PLAN		10,472	SUBSCRIPTIONS		2,721						
					EMPLOYEE PHYSICALS		10,477	DUES		9,424						
					INCENTIVES		2,816	PROMOTION		18,302						
					PENSION		40,992	LESS NONALLOWABLE DUES/SUB		(1,204)						
								Less: Public Relations Expense		(18,302)						
								Non-allowable advertising		(6,471)						
								Yellow page advertising		(1,088)						
TOTAL (agree to Schedule V, line 17, col. 1)								TOTAL (agree to Sch. V, line 20, col. 8)			25,637					
(List each licensed administrator separately.)				\$ 73,083												
B. Administrative - Other					Amount											
Description					\$											
TOTAL (agree to Schedule V, line 17, col. 3)				\$												
(Attach a copy of any management service agreement)																
C. Professional Services					Amount	Description		Line #	Amount	G. Schedule of Travel and Seminar**						
Vendor/Payee		Type								Description		Amount				
SIMUTIS LAW OFFICE		ATTORNEY/5500 PREP		\$ 5,006					\$	Out-of-State Travel		\$				
DUANE MORRIS LLP		ATTORNEY		31,641												
FOX CPA GROUP		AUDITOR		7,662												
RITA FINK, CPA		ACCOUNTANT		27,655						In-State Travel		3,220				
CAROL LEHMAN		ACCOUNTANT		956												
BENEFIT PLANNINC CONS		FLEX/HRA ADMIN		2,979						LESS INSERVICE		(2,212)				
CLIFTON GUNDERSON		401K PENSION AUDIT		8,425						NONALLOWABLE		(148)				
FR&R HEALTHCARE CONS		MEDICARE COST REPORT		4,309						Seminar Expense		10,621				
SMITH ADMUNDSON LLC		EMPLOYEE HANDBOOK		2,325												
AMERICAN UNITED LIFE		403 B PLAN ADMIN		760												
DECK & BARON		ATTORNEYS		700						NURSING TRAVEL		(595)				
SEE ATTACHED SCHEDULE				2,172						Entertainment Expense		()				
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL			\$	(agree to Sch. V, line 24, col. 8)						
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 94,590							TOTAL		\$ 10,886			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**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	NONE		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN \$5507, IL NURSING HOME ASSN \$100

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,796 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. _____

(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. \$ 350,016
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. \$ 20,660 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FOX CPA GROUP, LTD

(18) Have all costs which do not relate to the provision of long term care been adjusted 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? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT