

		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>0036285</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Richland Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/11</u> to <u>09/30/12</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>1066 W Main-PO Box 10</u> <u>Olney</u> <u>62450</u>																																																			
Number City Zip Code																																																			
County: <u>Richland</u>																																																			
Telephone Number: <u>(618)395-2437</u> Fax # <u>(618)392-2673</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>09/15/90</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY,NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 c 3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</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 _____	_____			
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		☐	Trust	_____																																															
		☐	Other _____	_____																																															
In the event there are further questions about this report, please contact:																																																			
Name: <u>Rita Armbrust</u>																																																			
Telephone Number: <u>618 548-0309</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) <u>01/30/13</u></td></tr><tr><td rowspan="6">Paid Preparer</td><td>(Type or Print Name) <u>Terry Elwood</u></td></tr><tr><td>(Title) <u>President</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td colspan="2">(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) <u>01/30/13</u>	Paid Preparer	(Type or Print Name) <u>Terry Elwood</u>	(Title) <u>President</u>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																			
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Facility Name & ID Number Richland Manor# 0036285 Report Period Beginning: 10/01/11 Ending: 09/30/12

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	5,369			5,369	13
14	TOTALS	5,369			5,369	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.68%

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

172 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

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

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

YES ☐NO ☒

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

Date started 09/15/90

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

YES ☒Date 07/13/91NO ☐

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 _____

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 09/30/12Fiscal Year: 09/30/12

* 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	58,664	5,169	3,217	67,050		67,050		67,050		1
2	Food Purchase		43,473		43,473	(1,778)	41,695	313	42,008		2
3	Housekeeping	30,678	5,778		36,456		36,456	4	36,460		3
4	Laundry		4,757		4,757		4,757		4,757		4
5	Heat and Other Utilities			10,324	10,324		10,324	1,540	11,864		5
6	Maintenance	3,999	2,415	5,206	11,620		11,620	482	12,102		6
7	Other (specify):* Garbage pickup			1,727	1,727		1,727	12	1,739		7
8	TOTAL General Services	93,341	61,592	20,474	175,407	(1,778)	173,629	2,351	175,980		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	178,178	6,858	5,564	190,600	(321)	190,279		190,279		10
10a	Therapy										10a
11	Activities	23,182	305		23,487		23,487		23,487		11
12	Social Services	1,449			1,449		1,449		1,449		12
13	CNA Training										13
14	Program Transportation			4,924	4,924	(676)	4,248		4,248		14
15	Other (specify):* H.A.TRAINING	4,690	100		4,790		4,790		4,790		15
16	TOTAL Health Care and Programs	207,499	7,263	10,488	225,250	(997)	224,253		224,253		16
	C. General Administration										
17	Administrative	64,755			64,755	(203)	64,552	15,000	79,552		17
18	Directors Fees							2,250	2,250		18
19	Professional Services			91,200	91,200		91,200	1,558	92,758		19
20	Dues, Fees, Subscriptions & Promotions			684	684		684	577	1,261		20
21	Clerical & General Office Expenses	33,239	7,518		40,757		40,757	5,180	45,937		21
22	Employee Benefits & Payroll Taxes			30,569	30,569	1,778	32,347	12,236	44,583		22
23	Inservice Training & Education					524	524		524		23
24	Travel and Seminar			113	113		113		113		24
25	Other Admin. Staff Transportation			2,239	2,239	241	2,480	1,688	4,168		25
26	Insurance-Prop.Liab.Malpractice			554	554		554	6,700	7,254		26
27	Other (specify):*										27
28	TOTAL General Administration	97,994	7,518	125,359	230,871	2,340	233,211	45,189	278,400		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	398,834	76,373	156,321	631,528	(435)	631,093	47,540	678,633		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			19,515	19,515		19,515	875	20,390			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,200	4,200			34
35	Rent-Equipment & Vehicles							2,400	2,400			35
36	Other (specify):*											36
37	TOTAL Ownership			19,515	19,515		19,515	7,475	26,990			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					435	435		435			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,062	36,062		36,062		36,062			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,062	36,062	435	36,497		36,497			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	398,834	76,373	211,898	687,105		687,105	55,015	742,120			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.)

		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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)	55,015	Pg 6a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 55,015		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 55,015		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.	x		\$ 435	L14	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			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 435		47

Richland Manor

ID#

0036285

Report Period Beginning:

10/01/11

Ending:

09/30/12

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
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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 Richland Manor # 0036285 Report Period Beginning: 10/01/11 Ending: 09/30/12

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

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

Summary B

09/30/12

[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
		Prairie Estates	Flora	(Marion County Horizon Center)	Salem	Home Office

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		See attached 6a	\$ 55,009	Marion County Horizon Center	0.00%	\$ 110,024	\$ 55,015	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			\$ 55,009			\$ 110,024	\$ * 55,015	14

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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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	Terry Elwood	Director	Board Member	0.00	1,150	2	6.00	Director Fee	\$ 1,150	L18, C7	1
2	Amanda Miller	Director	Board Member	0.00	550	1	3.00	Director Fee	550	L18, C7	2
3	Julie Quinn	Director	Board Member	0.00	550	1	3.00	Director Fee	550	L18, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,250		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

Marion County Horizon Center

Street Address

122 N Hotze Rd

City / State / Zip Code

Salem, IL 62881

Phone Number

(618 548-0309

Fax Number

(618 548-3720

	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	2	Food	Facilities	2	2	\$ 626	\$ 0	1	\$ 313	1
2	3	Housekeeping Supplies	Facilities	2	2	7	0	1	4	2
3	5	Utilities	Facilities	2	2	3,080	0	1	1,540	3
4	6	Maintenance Supplies	Facilities	2	2	504	0	1	252	4
5	6	Maintenance Repairs	Facilities	2	2	460	0	1	230	5
6	7	Garbage Pick up	Facilities	2	2	24	0	1	12	6
7	17	Management Fees	Facilities	2	2	30,000	0	1	15,000	7
8	18	Director Fees	Facilities	2	2	4,500	0	1	2,250	8
9	19	Accounting	Facilities	2	2	3,116	0	1	1,558	9
10	20	License Fees	Facilities	2	2	500	0	1	250	10
11	20	Dues & Subscriptions	Facilities	2	2	578	0	1	289	11
12	20	Employee Background Check	Facilities	2	2	75	0	1	38	12
13	21	Telephone	Facilities	2	2	2,753	0	1	1,377	13
14	21	Office Supplies	Facilities	2	2	2,421	0	1	1,211	14
15	21	Computer Expense	Facilities	2	2	5,183	0	1	2,592	15
16	22	W/C Insurance	Facilities	2	2	22,968	0	1	11,484	16
17	22	Emp. HealthIns.	Facilities	2	2	1,504	0	1	752	17
18	25	Gas & Oil	Facilities	2	2	1,856	0	1	928	18
19	25	Trans. Rep & Main	Facilities	2	2	1,520	0	1	760	19
20	26	Building Insurance	Facilities	2	2	13,399	0	1	6,700	20
21	30	Depreciation	Facilities	2	2	1,750	0	1	875	21
22	34	Other Rent	Facilities	2	2	8,400	0	1	4,200	22
23	35	Vehicle Rent	Facilities	2	2	4,800	0	1	2,400	23
24										24
25	TOTALS					\$ 110,024	\$		\$ 55,015	25

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/11 Ending: 09/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	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)						\$	\$ None			\$ None	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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.				\$ None	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	None	8
2008	None	9
2009	None	10
2010	None	11
2011	None	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Richland Manor COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0036285

CONTACT PERSON REGARDING THIS REPORT Rita Armbrust

TELEPHONE 618 548-0309 FAX #: 618 548-3720

A. Summary of Real Estate Tax Cost

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

(A)		(B)		(C)		(D)	
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>		<u>Tax Applicable to Nursing Home</u>	
1.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
2.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
3.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
4.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
5.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
6.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
7.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
8.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
9.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
10.	<u> </u>	<u> </u>	<u> </u>	\$	<u> </u>	\$	<u> </u>
TOTALS				\$	<u>None</u>	\$	<u> </u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	4,572	B. General Construction Type:	Exterior Vinyl	Frame Wood & Brick	Number of Stories	One
------------------------	--------------	--------------------------------------	-----------------------	-------------------------------	--------------------------	------------

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	25,425	1991	\$ 9,000	1
2					2
3	TOTALS	25,425		\$ 9,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1991	1985	\$ 347,410	\$ 13,896	25	\$ 13,896		\$ 294,136
5										
6										
7										
8										
	Improvement Type**									
9	Storage Shed		1987		869		15			869
10	Remodeling		1990		4,872	195	25	195		4,240
11	Storage Shed		1991		618		20			618
12	Wood Deck		1991		2,978		15			2,978
13	Paving/Concrete		1991		11,475		20			11,475
14	Lawn		1991		768		10			768
15	Landscaping		1991		740		10			740
16	Air Conditioning System		1994		1,500		15			1,500
17	Door, cabinet, countertop		1995		1,767		10			1,767
18	Driveway Work, Concrete		1997		5,280	264	20	264		4,070
19	Air Conditioning System (4 ton)		1997		1,242		5			1,242
20	Carpet/Installation		1999		9,217		10			9,217
21	Cabinets/Installation		1999		8,195		10			8,195
22	Garage (Van/Storage)		2000		22,718	1,136	20	1,136		14,105
23	Fence		2000		5,248	350	15	350		4,258
24	Concrete Driveway		2000		4,439	222	20	222		2,738
25	Garage Shelving		2000		1,176		10			1,176
26	Landscaping		2001		600		10			600
27	Air Conditioning/Heating System		2001		3,400		10			3,400
28	Bathroom Floor Replaced		2005		2,048	102	20	102		791
29	Roof and Guttering		2009		17,287	576	30	576		1,942
30	Handicapped Tub and Shower in 2 Bathrooms		2010		12,240	1,224	10	1,224		3,250
31	Wheelchair Ramp		2010		2,445	163	15	163		326
32	Fire Alarm System		2011		3,167	317	10	317		475
33	Air Conditioning		2012		2,200		15			
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)		\$ 473,899	\$ 18,445		\$ 18,445	\$	\$ 374,876	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	\$ 70,823	\$ 821	\$ 821	\$	10	\$ 69,575	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Equipment	519	74	74		7	157	74
75	TOTALS	\$ 71,342	\$ 895	\$ 895	\$		\$ 69,732	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	Facility Transportation	Dodge Caravan 2005	3/22/2005	\$ 20,423	\$	\$	\$	5	\$ 20,423	76
77	Facility Transportation	GMC Envoy 2004	12/10/2010	5,250	1,050	1,050		5	1,925	77
78										78
79										79
80	TOTALS			\$ 25,673	\$ 1,050	\$ 1,050	\$		\$ 22,348	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 579,914 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,390 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,390 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 466,956 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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Office	1987		3/9/92	4,200			5
6								6
7	TOTAL				\$ 4,200			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	Facility Transportation	2010 GMC Terrain	\$ 200.00	\$ 2,400	17
18					18
19					19
20					20
21	TOTAL		\$ 200.00	\$ 2,400	21

10. Effective dates of current rental agreement:

Beginning 03/09/2009

Ending 03/09/2014

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

	Fiscal Year Ending	Annual Rent
12.	09/30/2013	\$ 4,200
13.	09/30/2014	\$ 4,200
14.	Month by Month	\$ 4,200

* 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

50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☒

IN OTHER FACILITY

☐

HOURS PER CNA

80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		100		100
3	Classroom Wages (a)		1,650		1,650
4	Clinical Wages (b)		2,640		2,640
5	In-House Trainer Wages (c)		400		400
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,790	\$	\$ 4,790
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,790		

C. CONTRACTUAL INCOME

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

\$

None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(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.

HFS 3745 (N-4-99)

IL478-2471

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ None	None	\$ None	\$ None	None	\$ None	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 27,289	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	317,836		3
4	Supply Inventory (priced at COST)	4,554		4
5	Short-Term Investments			5
6	Prepaid Insurance	83		6
7	Other Prepaid Expenses	529		7
8	Accounts Receivable (owners or related parties)	50,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 400,291	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000		13
14	Buildings, at Historical Cost	391,103		14
15	Leasehold Improvements, at Historical Cost	82,794		15
16	Equipment, at Historical Cost	91,246		16
17	Accumulated Depreciation (book methods)	(463,453)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 110,690	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 510,981	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,608	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,097		30
31	Accrued Taxes Payable (excluding real estate taxes)	619		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	6,378		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 20,702	\$	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)	\$ 20,702	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 490,279	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 510,981	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 551,696	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 551,696	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,417)	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)	\$ (61,417)	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)	\$ 490,279	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Richland Manor# 0036285Report Period Beginning: 10/01/11Ending: 09/30/12

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	\$ 614,871	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 614,871	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	2,537	10
11	CNA Training Reimbursements	6,379	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	435	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,351	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,466	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,466	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 625,688	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	175,407	31
32	Health Care	224,466	32
33	General Administration	231,655	33
	B. Capital Expense		
34	Ownership	19,515	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	36,062	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 687,105	40
41	Income before Income Taxes (line 30 minus line 40)**	(61,417)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (61,417)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 614,871	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	None	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 614,871	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	298	298	7,077	23.75	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,382	1,446	12,957	8.96	9
10	Activity Assistants	965	965	10,225	10.60	10
11	Social Service Workers	60	60	1,449	24.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,489	1,569	20,408	13.01	14
15	Cook Helpers/Assistants	3,162	3,306	38,256	11.57	15
16	Dishwashers					16
17	Maintenance Workers	198	198	3,999	20.20	17
18	Housekeepers	2,367	2,598	30,678	11.81	18
19	Laundry					19
20	Administrator	1,000	1,080	30,121	27.89	20
21	Assistant Administrator	1,000	1,040	26,663	25.64	21
22	Other Administrative	400	400	7,971	19.93	22
23	Office Manager	900	900	21,500	23.89	23
24	Clerical	700	708	11,739	16.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	800	840	15,998	19.05	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	15,394	16,010	155,103	9.69	30
31	Medical Records					31
32	Other Health Care H.A.T.	520	520	4,290	8.25	32
33	Other(specify) H.A.T. TRAINER	20	20	400	20.00	33
34	TOTAL (lines 1 - 33)	30,655	31,958	\$ 398,834 *	\$ 12.48	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	58	\$ 3,217	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	851	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	135	L10, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	40	3,300	L10, C3	47
48	Psychologist Consultant	6	540	L10, C3	48
49	TOTAL (lines 35 - 48)	119	\$ 8,043		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)	None	\$ None		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Trena Briscoe, LNHA	NHA	0	\$ 30,121	Workers' Compensation Insurance		\$ 11,484	IDPH License Fee	\$ 0	
Libby Riggs	Asst. Admn	0	26,663	Unemployment Compensation Insurance		0	Advertising: Employee Recruitment	256	
Charlotte Watton, LNHA, MSW	Administrative	0	7,971	FICA Taxes		30,511	Health Care Worker Background Check		
				Employee Health Insurance		752	(Indicate # of checks performed <u>6</u>)	133	
				Employee Meals		1,778	Patient Background Checks <u>1</u>	10	
				Illinois Municipal Retirement Fund (IMRF)*			Dues/Subscriptions	404	
				TD/TB Vaccinations for Employees		58	Licenses	458	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 64,755						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 44,583		
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Health Care Mgmt. Corp.	Admn. Consulting Fees	\$ 91,200				\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Food Service Sanitation	53	
							End of Life	60	
							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.)			\$ 91,200	\$ None			TOTAL 113		

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

No
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10
- (6)

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

\$ 2,406 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (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.
This amount is to be recorded on line 42 of Schedule V.

\$ 36,062
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

Yes

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 1,778
N/A
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
435

c.

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

59.46%

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

No

(17)

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

No

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

N/A

1 Employee Benefits and Payroll Taxes, Line 22	\$1,778	
Food Purchase, Line 2		\$1,778

To reclassify free employee meals from food costs
to employee benefits

2 Medically Necessary Transportation, Line 38	\$435	
Program Transportation, Line 14		\$435

To reclassify medical transportation for clients per
the separate DPA contract

3 Inservice Training & Education, Line 23	\$524	
Nursing and Medical Records, Line 10		\$321
Administrative, Line 17		\$203

To re-classify in-service training paid to instructors as follows:

10/28/11 Briscoe--CPR Refresher
10/31/11 Briscoe/Riggs--Neti Pot
12/15/11 Riggs/Briscoe--Active Treatment Rev
12/15/11 Riggs--Fall Prev/Safety
1/3/12 Briscoe--Beh/Confidentiality/Active Treatment
2/14/12 Riggs--Emergency Preparedness
3/22/12 Briscoe--CPR Refresher
3/22/12 Riggs/Briscoe--CD-BSP Review
5/5/12 Riggs--Emerg Evac Plan/Fire Safety
5/11/12 Riggs--Health Care Plan
5/15/12 Riggs--Hot Weather Emergency
7/9/12 Briscoe--Resident Rights/reporting & Prev of Abuse & Neglect
9/4/12 Riggs--Oral Care
9/10/12 Riggs--O2 Use/Pulse O2 Use/C-pap Use

4 Other Admn. Staff Transportation, Line 25	\$241	
Program Transportation, Line 14		\$241

According to the facility's van mileage log, 7,518 miles
were driven this fiscal year (76,608 less 69,090.)
According to the Envoy mileage log, 1,379 miles

were driven this fiscal year (102,476 less 101,097.)
Of that, 476 miles were for unloaded errand miles for the
facility. Therefore:

Line 25 Other Admn. Travel = $(476 \text{ miles} / (7,518 + 1,379 \text{ miles}) \times \$4500 = \$241$

Schedule V Line Reference	Item	Total Marion County Horizon Center Expenses	% of Ownership	Allocation Prairie Estates	Richland Manor
2	Food	\$626	0%	\$313	\$313
3	Housekeeping Supplies	\$7	0%	\$4	\$4
5	Utilities	\$3,080	0%	\$1,540	\$1,540
6	Maintenance Supplies	\$504	0%	\$252	\$252
6	Maintenance Repairs	\$460	0%	\$230	\$230
7	Garbage Pick-up	\$24	0%	\$12	\$12
17	Management Fees	\$30,000	0%	\$15,000	\$15,000
18	Director Fees	\$4,500	0%	\$2,250	\$2,250
19	Accounting	\$3,116	0%	\$1,558	\$1,558
20	License fees	\$500	0%	\$250	\$250
20	Dues & Subscriptions	\$578	0%	\$289	\$289
20	Employee Background	\$75	0%	\$38	\$38
21	Telephone	\$2,753	0%	\$1,377	\$1,377
21	Office Supplies	\$2,421	0%	\$1,211	\$1,211
21	Computer Expense	\$5,183	0%	\$2,592	\$2,592
22	W/C Insurance	\$22,968	0%	\$11,484	\$11,484
22	Emp. Health Ins.	\$1,504	0%	\$752	\$752
22	State Unemp Taxes	\$0	0%	\$0	\$0
25	Gas & Oil	\$1,856	0%	\$928	\$928
25	Trans. Rep & Main.	\$1,520	0%	\$760	\$760
26	Building Insurance	\$13,399	0%	\$6,700	\$6,700
30	Depreciation	\$1,750	0%	\$875	\$875
34	Other Rent	\$8,400	0%	\$4,200	\$4,200
35	Vehicle Rent	<u>\$4,800</u>	0%	<u>\$2,400</u>	<u>\$2,400</u>
		<u>\$110,024</u>		<u>\$55,014</u>	<u>\$55,014</u>

	#0036277 Prairie <u>Estates</u>	#0036285 Richland <u>Manor</u>	<u>Total</u>
Terry Elwood	\$1,150	\$1,150	\$2,300
Amanda Miller	\$550	\$550	\$1,100
Julie Quinn	<u>\$550</u>	<u>\$550</u>	<u>\$1,100</u>
Totals	<u>\$2,250</u>	<u>\$2,250</u>	<u>\$4,500</u>

	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Straight Line Depreciation</u>	<u>Adjustment</u>	<u>Component Life</u>	<u>Accm Dep.</u>
Equipment (Purchased in Prior Years)						
Home Office	28,170	\$148			7	
% Home Office Allocated		<u>x.5</u>				
	\$9,564	\$74	\$74			\$157
Richland Manor Equipment	<u>\$61,778</u>	<u>\$821</u>	<u>\$821</u>	0		<u>\$69,575</u>
Total XI-C, Line 75	\$71,342	\$895	\$895	0		\$69,732

Travel and Seminar, Line 24:

<u>Job Title</u>	<u>Date</u>	<u>Location</u>	<u>Title</u>	<u>Sponsor</u>	<u>Seminar Cost</u>	<u>Mileage Paid</u>	<u>Hotel Cost</u>	<u>Food Costs</u>	<u>Total Costs</u>
L.N.H.A. & Asst. Admn	4/27/2012	Olney	"End-of-Life Ethics"	Hospice Fdn	\$60				\$60
Cook/A.D.	7/17/2012	Olney, IL	"Food Service Sanitation"	IL Eastern Comm College	\$53	\$0 <u>\$0</u>	\$0 <u>\$0</u>	\$0 <u>\$0</u>	\$53
					\$113	\$0	\$0	\$0	<u>\$113</u>

Other Admn. Transportation, Line 25

Reimbursement to employees for administrative miles were reimbursed at a rate of \$.45/mile for the period 10/01/11 to 09/30/12. Detailed logs of these miles are maintained at the facility.

Tt miles reimbursed - 4975 miles x \$.45/mile	\$2,239
Less miles re-classed to Travel & Seminar	\$0
Rep/Main, gas&oil for vehicles (fm home office)	\$1,688
476 miles logged on van/Envoy for admin use	<u>\$241</u>
Line 25, Column 8	<u>\$4,168</u>

Schedule XX, Line 12:

Riggs's pay has been allocated as follows:

QMRP - 24%
Assistant Administrator - 40%
Housekeeping - 10%
Clerical - 10%
Maintenance - 6%
Dietary - 10%

Watton's hours have been allocated as follows:

Social Worker - 10%
Administrative Assistant - 55%
Clerical - 35%