

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0035196

Facility Name: Tibstra House

Address: 271 East 161st Street South Holland 60473
Number City Zip Code

County: Cook

Telephone Number: (708) 596-4442 Fax # (708) 596-4486

HFS ID Number:

Date of Initial License for Current Owners: 1/24/90

Type of Ownership:

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

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven Goudzwaard Telephone Number: (708) 371-0800
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/11 to 6/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Steven J. Goudzwaard
(Title) Director of Finance

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Tibstra House# 0035196 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	5,356			5,356	13
14	TOTALS	5,356			5,356	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.46%

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

500 (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)
_____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 1/24/90

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 _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 2012 Fiscal Year: 2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	32,021	1,754	1,995	35,770		35,770		35,770			1
2	Food Purchase		45,629		45,629		45,629		45,629			2
3	Housekeeping	16,218	4,116	843	21,177		21,177		21,177			3
4	Laundry		1,160		1,160		1,160		1,160			4
5	Heat and Other Utilities			8,860	8,860		8,860		8,860			5
6	Maintenance	19,078	3,467	5,291	27,836		27,836		27,836			6
7	Other (specify):* scavenger			1,568	1,568		1,568		1,568			7
8	TOTAL General Services	67,317	56,126	18,557	142,000		142,000		142,000			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	312,409	2,076	1,148	315,633		315,633		315,633			10
10a	Therapy	5,403	52	999	6,454		6,454		6,454			10a
11	Activities	27,666	2,197		29,863		29,863		29,863			11
12	Social Services	4,052			4,052		4,052		4,052			12
13	CNA Training											13
14	Program Transportation		6,886		6,886		6,886		6,886			14
15	Other (specify):* Program Director	31,648			31,648		31,648		31,648			15
16	TOTAL Health Care and Programs	381,178	11,211	5,447	397,836		397,836		397,836			16
	C. General Administration											
17	Administrative	38,032			38,032		38,032		38,032			17
18	Directors Fees											18
19	Professional Services			7,087	7,087		7,087		7,087			19
20	Dues, Fees, Subscriptions & Promotions			12,140	12,140		12,140		12,140			20
21	Clerical & General Office Expenses	14,329	1,691	5,644	21,664		21,664	(3,717)	17,947			21
22	Employee Benefits & Payroll Taxes			114,192	114,192		114,192	(567)	113,625			22
23	Inservice Training & Education			123	123		123		123			23
24	Travel and Seminar			1,156	1,156		1,156	(122)	1,034			24
25	Other Admin. Staff Transportation			300	300		300		300			25
26	Insurance-Prop.Liab.Malpractice			11,436	11,436		11,436		11,436			26
27	Other (specify):* miscellaneous		857		857		857		857			27
28	TOTAL General Administration	52,361	2,548	152,078	206,987		206,987	(4,406)	202,581			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	500,856	69,885	176,082	746,823		746,823	(4,406)	742,417			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			26,187	26,187		26,187		26,187			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			26,187	26,187		26,187		26,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,064	46,064		46,064		46,064			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			46,064	46,064		46,064		46,064			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	500,856	69,885	248,333	819,074		819,074	(4,406)	814,668			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(3,717)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(689)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,406)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (4,406)		37

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

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

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

Tibstra House

ID# 0035196

Report Period Beginning: 7/1/11

Ending: 6/30/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Non Direct Care Seminars	\$ (122)	24	1
2	fundraising employee benefits	(567)	22	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	(689)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tibstra House # 0035196 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	(3,717)	0	0	0	0	0	0	0	0	0	0	(3,717)	21
22	Employee Benefits & Payroll Taxes	(567)	0	0	0	0	0	0	0	0	0	0	(567)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(122)	0	0	0	0	0	0	0	0	0	0	(122)	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	(4,406)	0	0	0	0	0	0	0	0	0	0	(4,406)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,406)	0	0	0	0	0	0	0	0	0	0	(4,406)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(4,406)	0	0	0	0	0	0	0	0	0	0	(4,406)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethshan Association	100%	Bethshan Assoc I & Bethshan Assoc II	Palos Heights	Bethshan Foundation	Palos Heights	Charitable Corp

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

X 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.

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	Brian Dobben, President	BOD						1
2	Ira Slagter, Vice President	BOD						2
3	Donald Poortenga, Treasurer	BOD						3
4	Kim Lagestee-Mulder, Secretary	BOD						4
5	Wayne Boss	BOD						5
6	Jori Brink	BOD						6
7	Judy Gill	BOD						7
8	Tom Lemmenes	BOD						8
9	Ann Payne	BOD						9
10	Julie Sather	BOD						10
11	Howard VanDyke	BOD						11
12	James VanKampen	BOD						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									\$		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

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)						\$		\$			\$	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		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
Tibstra House

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0035196

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()
FAX #: ()

A.
Summary of Real Estate Tax Cost

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

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

B.
Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,985

B. General Construction Type: Exterior brick Frame wood Number of Stories 1 w/basement

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).

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	<u>16 bed ICF w/garage</u>	<u>18,000</u>	<u>1989</u>	<u>\$ 25,000</u>	1
2					2
3	TOTALS	18,000		\$ 25,000	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1990	1990	\$ 408,781	\$ 10,220	40	\$ 10,220		\$ 229,315
5										
6										
7										
8										
	Improvement Type**									
9	Garage		1992		9,830	492	20	492		9,595
10	Landscaping		1990		2,503	63	40	63		1,369
11	Driveway; parking		1990		33,639		15			33,639
12	Washroom remodeling		1996		20,165	1,008	20	1,008		15,743
13	Kitchen sink & counter tops		2001		2,635		10			2,635
14	Front door installation		2007		1,250	83	15	83		469
15	Water heater		2007		5,860	586	10	586		3,018
16	Guardian Elite Generator		2008		17,300	1,730	10	1,730		8,003
17	Roof		2008		12,985	649	20	649		2,978
18	Siding and Facia		2009		4,500	300	15	300		989
19	Lennox Furnace/Air Conditioner		2010		12,540	836	15	836		2,039
20	Landscaping Edging / Bushes		2010		1,470	147	10	147		251
21	Valve Replacement		2010		4,650	233	20	233		400
22	Install accessible ceramic tiled showers (2) with plumbing fixtures		2012		10,550	177	15	177		177
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 548,658	\$ 16,524		\$ 16,524	\$	\$ 310,620	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	\$ 17,518	\$ 2,412	\$ 2,412	\$		\$ 10,273	71
72	Current Year Purchases	150	6	6			6	72
73	Fully Depreciated Assets	97,193	160	160			97,193	73
74								74
75	TOTALS	\$ 114,861	\$ 2,578	\$ 2,578	\$		\$ 107,472	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	client transportation	vans	2006/2008	\$ 54,043	\$ 5,347	\$ 5,347	\$	5	\$ 50,527	76
77	Executive Director	Toyota Prius	2010	2,643	528	528		5	1,242	77
78	Maintenance	Ford superduty/Ford F150	2009/2011	6,877	1,210	1,210		5	2,722	78
79	maintenance	Silverado	2005	disposed					disposed	79
80	TOTALS			\$ 63,563	\$ 7,085	\$ 7,085	\$		\$ 54,491	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 752,082	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,187	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,187	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)	\$ 472,583	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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.

** Staff are trained in other facility

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

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

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 697,691	\$ 26,355	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	302,361	1,596,417	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,225	29,724	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,012,277	\$ 1,652,496	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	744,175	13
14	Buildings, at Historical Cost	548,658	6,531,800	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	203,425	1,974,936	16
17	Accumulated Depreciation (book methods)	(472,583)	(4,544,794)	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)	\$ 304,500	\$ 4,706,117	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,316,777	\$ 6,358,613	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 87,272	\$ 374,826	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		661,409	29
30	Accrued Salaries Payable	31,756	270,016	30
31	Accrued Taxes Payable (excluding real estate taxes)	676	6,408	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,048	33
34	Deferred Compensation	229	1,609	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)	\$ 119,933	\$ 1,327,316	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		613,550	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)	\$	\$ 613,550	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 119,933	\$ 1,940,866	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,196,844	\$ 4,417,747	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,316,777	\$ 6,358,613	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,194,109	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,194,109	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(11,044)	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)	\$ (11,044)	17
	B. Transfers (Itemize):		
18	Bathroom remodeling	10,550	18
19	Ford F250	3,229	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 13,779	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,196,844	24 *

* This must agree with page 17, line 47.

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	\$ 808,030	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 808,030	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy		6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue			
9 Payments for Education		9	
10 Other Government Grants		10	
11 CNA Training Reimbursements		11	
12 Gift and Coffee Shop		12	
13 Barber and Beauty Care		13	
14 Non-Patient Meals		14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs		17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray		20	
21 Other Medical Services		21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***		25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 808,030	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	142,000	31	
32 Health Care	397,836	32	
33 General Administration	206,987	33	
B. Capital Expense			
34 Ownership	26,187	34	
C. Ancillary Expense			
35 Special Cost Centers		35	
36 Provider Participation Fee	46,064	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 819,074	40	
41 Income before Income Taxes (line 30 minus line 40)**	(11,044)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (11,044)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 650,202	44	
45 Private Pay - Net Inpatient Revenue		45	
46 Medicare - Net Inpatient Revenue		46	
47 Other-(specify) <u>SS/VA</u>	156,046	47	
48 Other-(specify) <u>client fees</u>	1,782	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 808,030	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	1,159	1,234	33,382	27.05	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	155	179	5,403	30.18	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,902	2,026	27,666	13.66	9
10	Activity Assistants					10
11	Social Service Workers	99	108	4,052	37.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,838	2,112	32,021	15.16	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	738	835	19,078	22.85	17
18	Housekeepers	980	1,266	16,218	12.81	18
19	Laundry					19
20	Administrator	193	246	16,136	65.59	20
21	Assistant Administrator					21
22	Other Administrative	487	560	21,896	39.10	22
23	Office Manager					23
24	Clerical	686	782	14,329	18.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,101	2,411	53,952	22.38	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,525	18,432	225,075	12.21	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Program Director</u>	893	1,060	31,648	29.86	33
34	TOTAL (lines 1 - 33)	27,756	31,251	\$ 500,856 *	\$ 16.03	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	33	\$ 1,995	1-3	35
36	Medical Director	21	3,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1	24	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	24	975	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	4	1,148	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	83	\$ 7,442		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

STATE OF ILLINOIS

0035196

Report Period Beginning:

7/1/11

Page 21

Ending: 6/30/12

Facility Name & ID Number

Tibstra House

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>Joseph Lanenga</td> <td>Executive Director</td> <td>0</td> <td>\$ 16,136</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 16,136</td> </tr> </table>				Name	Function	Ownership %	Amount	Joseph Lanenga	Executive Director	0	\$ 16,136																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 16,136	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>Workers' Compensation Insurance</td><td>\$ 11,014</td></tr> <tr><td>Unemployment Compensation Insurance</td><td> </td></tr> <tr><td>FICA Taxes</td><td>35,629</td></tr> <tr><td>Employee Health Insurance</td><td>52,086</td></tr> <tr><td>Employee Meals</td><td> </td></tr> <tr><td>Illinois Municipal Retirement Fund (IMRF)*</td><td> </td></tr> <tr><td>Pension</td><td>11,327</td></tr> <tr><td>Other Employee Benefits</td><td>3,569</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 113,625</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 11,014	Unemployment Compensation Insurance		FICA Taxes	35,629	Employee Health Insurance	52,086	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Pension	11,327	Other Employee Benefits	3,569									TOTAL (agree to Schedule V, line 22, col.8)		\$ 113,625	F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>IDPH License Fee</td><td>\$ </td></tr> <tr><td>Advertising: Employee Recruitment</td><td>77</td></tr> <tr><td>Health Care Worker Background Check</td><td>109</td></tr> <tr><td>(Indicate # of checks performed 3)</td><td> </td></tr> <tr><td>Patient Background Checks</td><td> </td></tr> <tr><td>Employee Professional Fees/Dues</td><td>242</td></tr> <tr><td>Sams Club/ATT/filing fee</td><td>46</td></tr> <tr><td>IARF/Inst on Public Policy</td><td>1,591</td></tr> <tr><td>IDPH</td><td>10,000</td></tr> <tr><td>Village of South Holland</td><td>75</td></tr> <tr><td>Less: Public Relations Expense</td><td>()</td></tr> <tr><td>Non-allowable advertising</td><td>()</td></tr> <tr><td>Yellow page advertising</td><td>()</td></tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 12,140</td> </tr> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment	77	Health Care Worker Background Check	109	(Indicate # of checks performed 3)		Patient Background Checks		Employee Professional Fees/Dues	242	Sams Club/ATT/filing fee	46	IARF/Inst on Public Policy	1,591	IDPH	10,000	Village of South Holland	75	Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,140
Name	Function	Ownership %	Amount																																																																																																				
Joseph Lanenga	Executive Director	0	\$ 16,136																																																																																																				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 16,136																																																																																																				
Description	Amount																																																																																																						
Workers' Compensation Insurance	\$ 11,014																																																																																																						
Unemployment Compensation Insurance																																																																																																							
FICA Taxes	35,629																																																																																																						
Employee Health Insurance	52,086																																																																																																						
Employee Meals																																																																																																							
Illinois Municipal Retirement Fund (IMRF)*																																																																																																							
Pension	11,327																																																																																																						
Other Employee Benefits	3,569																																																																																																						
TOTAL (agree to Schedule V, line 22, col.8)		\$ 113,625																																																																																																					
Description	Amount																																																																																																						
IDPH License Fee	\$																																																																																																						
Advertising: Employee Recruitment	77																																																																																																						
Health Care Worker Background Check	109																																																																																																						
(Indicate # of checks performed 3)																																																																																																							
Patient Background Checks																																																																																																							
Employee Professional Fees/Dues	242																																																																																																						
Sams Club/ATT/filing fee	46																																																																																																						
IARF/Inst on Public Policy	1,591																																																																																																						
IDPH	10,000																																																																																																						
Village of South Holland	75																																																																																																						
Less: Public Relations Expense	()																																																																																																						
Non-allowable advertising	()																																																																																																						
Yellow page advertising	()																																																																																																						
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,140																																																																																																					
B. Administrative - Other <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>Steven Goudzwaard, Director of Finance</td><td>\$ 12,095</td></tr> <tr><td>Jean Voss, Director of Special Projects</td><td>9,801</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td>\$ 21,896</td> </tr> </table>				Description	Amount	Steven Goudzwaard, Director of Finance	\$ 12,095	Jean Voss, Director of Special Projects	9,801					TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$ 21,896	E. Schedule of Non-Cash Compensation Paid to Owners or Employees <table> <tr> <th>Description</th> <th>Line #</th> <th>Amount</th> </tr> <tr><td>personal use of auto (Exec.Dir)</td><td> </td><td>\$ 819</td></tr> <tr><td>personal use of auto (Maint.)</td><td> </td><td>307</td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL</td> <td>\$ 1,126</td> </tr> </table>				Description	Line #	Amount	personal use of auto (Exec.Dir)		\$ 819	personal use of auto (Maint.)		307																						TOTAL		\$ 1,126	G. Schedule of Travel and Seminar** <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>Out-of-State Travel</td><td>\$ </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>In-State Travel</td><td>14</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Seminar Expense</td><td>1,020</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Entertainment Expense</td><td>()</td></tr> <tr><td>(agree to Sch. V, line 24, col. 8)</td><td> </td></tr> <tr> <td>TOTAL</td> <td>\$ 1,034</td> </tr> </table>				Description	Amount	Out-of-State Travel	\$					In-State Travel	14					Seminar Expense	1,020					Entertainment Expense	()	(agree to Sch. V, line 24, col. 8)		TOTAL	\$ 1,034																				
Description	Amount																																																																																																						
Steven Goudzwaard, Director of Finance	\$ 12,095																																																																																																						
Jean Voss, Director of Special Projects	9,801																																																																																																						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$ 21,896																																																																																																					
Description	Line #	Amount																																																																																																					
personal use of auto (Exec.Dir)		\$ 819																																																																																																					
personal use of auto (Maint.)		307																																																																																																					
TOTAL		\$ 1,126																																																																																																					
Description	Amount																																																																																																						
Out-of-State Travel	\$																																																																																																						
In-State Travel	14																																																																																																						
Seminar Expense	1,020																																																																																																						
Entertainment Expense	()																																																																																																						
(agree to Sch. V, line 24, col. 8)																																																																																																							
TOTAL	\$ 1,034																																																																																																						
C. Professional Services <table> <tr> <th>Vendor/Payee</th> <th>Type</th> <th>Amount</th> </tr> <tr><td>Dreyer Ooms & VanDrunen</td><td>audit & accounting</td><td>\$ 3,762</td></tr> <tr><td>ADP</td><td>payroll preparation</td><td>303</td></tr> <tr><td>Sandata Technologies</td><td>payroll preparation</td><td>166</td></tr> <tr><td>Open Systems</td><td>payroll consulting</td><td>163</td></tr> <tr><td>Paycor</td><td>payroll preparation</td><td>1,656</td></tr> <tr><td>Dianne Kariotis</td><td>investigative services</td><td>1,000</td></tr> <tr><td>Wessels & Pautsch</td><td>legal services</td><td>37</td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)</td> <td>\$ 7,087</td> </tr> </table>				Vendor/Payee	Type	Amount	Dreyer Ooms & VanDrunen	audit & accounting	\$ 3,762	ADP	payroll preparation	303	Sandata Technologies	payroll preparation	166	Open Systems	payroll consulting	163	Paycor	payroll preparation	1,656	Dianne Kariotis	investigative services	1,000	Wessels & Pautsch	legal services	37													TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 7,087	* Attach copy of IMRF notifications				**See instructions.																																																								
Vendor/Payee	Type	Amount																																																																																																					
Dreyer Ooms & VanDrunen	audit & accounting	\$ 3,762																																																																																																					
ADP	payroll preparation	303																																																																																																					
Sandata Technologies	payroll preparation	166																																																																																																					
Open Systems	payroll consulting	163																																																																																																					
Paycor	payroll preparation	1,656																																																																																																					
Dianne Kariotis	investigative services	1,000																																																																																																					
Wessels & Pautsch	legal services	37																																																																																																					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 7,087																																																																																																					

**TIBSTRA HOUSE
SCHEDULE OF STAFF TRAVEL
FY 2012**

		<u>TRAVEL</u> <u>EXPENSE</u>	<u>SEMINARS</u> <u>COST</u>
	Staff intra-agency travel for meetings at central office, etc.		
	<u>11-600-675 Allocation</u>		
9/16/2011	ARC No More Meltdowns: Managing & Preventing Out-of-Control Behavior Alsip, IL David Tiemersma, Administrator		87.00
9/12/2011	IBP How the Brain Forms New Habits Oak Brook, IL David Tiemersma, Program Director		47.40
1/4/2012	ARC 10th Annual QSP Leadersip Conference Alsip, IL Amy Tiemersma, LCSW David Tiemersma, Program Director Peggy Mollema, QSP		16.62 67.50 135.00
2/1/2012	CCIT Portrait of Dementia: Helping People Live Well Palos Heights, IL Peggy Mollema, QSP		15.00
3/13/2012	Safe Food Handlers Food Service Sanitation Lansing, IL Lois Buikema, Dietary Mattie Heads, QSP		80.00 80.00
5/14/2012	IBP Why We Worry: Understanding & Treating Anxiety Disorders Oak Brook, IL		

	Frea Mars, Program Director	13.76	44.40
6/7-9/2012	APTA Annual Conference Tampa, FL Teresa Walus, OT/PT		67.09
7/25/2012	INR Sleep Deprivation, Autism, & ADHD Tinley Park, IL Frea Mars, Program Director		81.00
9/27/2012	ARC Bringing it all Together: Living with Autism Tinley Park, IL Laura Kirchhoff, Program Director Christine Konior, DON Frea Mars, Program Director Peggy Mollema, QSP		19.94 19.95 97.20 162.00
		13.76	1,020.10
			1,033.86

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? no

If YES, give association name and amount. _____

(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? 5 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 570 Line 10-2

(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. \$ 46,064

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

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

If YES, attach an explanation of the allocation. _____

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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. \$ 0

Has any meal income been offset against related costs? n/a Indicate the amount. \$ _____

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? no

If YES, attach a complete explanation. _____

b. Do you have a separate contract with the Department to provide medical transportation for residents? no

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

c. What percent of all travel expense relates to transportation of nurses and patients? 100%

d. Have vehicle usage logs been maintained? no

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? yes

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: Dreyer, Ooms, & Van Drunen Ltd

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

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

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

HFS 3745 (N-4-99)

IL478-2471

Tibstra House
ID # 0035196
Schedule XX (12) Explanation of Salary Allocation
FY2012

Dave Tiemersma	(Ln 15-1)	Program Director Salary	\$ 24,082
	(Ln 10-1)	QMRP Salary	\$ 7,527
Frea Mars	(Ln 15-1)	Program Director Salary	\$ 8,337
	(Ln 10-1)	QMRP Salary	\$ 2,606