

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0049718</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Galena Stauss Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/15</u> to <u>9/30/16</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>215 Summit Street</u> <u>Galena</u> <u>61036</u>																									
Number City Zip Code																									
County: <u>Jo Daviess</u>																									
Telephone Number: <u>(815) 776-1340</u> Fax # <u>(815) 776-7274</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Tracy Bauer</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) <u>See Accountant's Comilation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Paul Traczek, CPA</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Wipfli, LLP</u> <u>3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u></td></tr><tr><td>(Telephone) <u>(715) 858-6619</u> Fax # <u>(715) 832-2345</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Tracy Bauer</u>	(Title) <u>Chief Executive Officer</u>	(Signed) <u>See Accountant's Comilation Report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>Paul Traczek, CPA</u> <u>Partner</u>	(Firm Name & Address) <u>Wipfli, LLP</u> <u>3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u>	(Telephone) <u>(715) 858-6619</u> Fax # <u>(715) 832-2345</u>												
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	(Telephone) <u>(715) 858-6619</u> Fax # <u>(715) 832-2345</u>																								
Date of Initial License for Current Owners: <u>01-01-1970</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY,NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>20-4560540</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>20-4560540</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☒ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☒ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code <u>20-4560540</u>	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Marie Wamsley</u> Telephone Number: <u>(815) 776-7277</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

0049718 Report Period Beginning: 10/01/15 Ending: 9/30/16

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	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	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			41	41	8
9	SNF/PED					9
10	ICF	11,968	6,394		18,362	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,968	6,394	41	18,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.45%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

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 5 and days of care provided 39

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: N/A Fiscal Year: 9/30/2016
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number		Galena Stauss Nursing Home		STATE OF ILLINOIS		#	0049718	Report Period Beginning:		10/01/15	Ending:		Page 3	9/30/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)														
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY				
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10			
	A. General Services													
1	Dietary	106,677		63,250	169,927		169,927		169,927				1	
2	Food Purchase		101,976		101,976		101,976		101,976				2	
3	Housekeeping	48,711		9,443	58,154		58,154		58,154				3	
4	Laundry			64,269	64,269		64,269		64,269				4	
5	Heat and Other Utilities			34,078	34,078		34,078		34,078				5	
6	Maintenance	26,241		34,616	60,857		60,857		60,857				6	
7	Other (specify):*												7	
8	TOTAL General Services	181,629	101,976	205,656	489,261		489,261		489,261				8	
	B. Health Care and Programs													
9	Medical Director												9	
10	Nursing and Medical Records	1,201,883		125,992	1,327,875		1,327,875		1,327,875				10	
10a	Therapy												10a	
11	Activities												11	
12	Social Services												12	
13	CNA Training												13	
14	Program Transportation												14	
15	Other (specify):* Incontinent Supplies			56,242	56,242		56,242		56,242				15	
16	TOTAL Health Care and Programs	1,201,883		182,234	1,384,117		1,384,117		1,384,117				16	
	C. General Administration													
17	Administrative	91,263		41,009	132,272		132,272		132,272				17	
18	Directors Fees												18	
19	Professional Services												19	
20	Dues, Fees, Subscriptions & Promotions												20	
21	Clerical & General Office Expenses	4,936		2,218	7,154		7,154		7,154				21	
22	Employee Benefits & Payroll Taxes			341,564	341,564		341,564		341,564				22	
23	Inservice Training & Education												23	
24	Travel and Seminar												24	
25	Other Admin. Staff Transportation												25	
26	Insurance-Prop.Liab.Malpractice												26	
27	Other (specify):*												27	
28	TOTAL General Administration	96,199		384,791	480,990		480,990		480,990				28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,479,711	101,976	772,681	2,354,368		2,354,368		2,354,368				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.

SEE ACCOUNTANTS' PREPARATION REPORT

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			47,530	47,530	6,831	54,361		54,361			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					9,531	9,531		9,531			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			16,362	16,362	(16,362)						36
37	TOTAL Ownership			63,892	63,892		63,892		63,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	8,607			8,607		8,607		8,607			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,038	128,038		128,038		128,038			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	8,607		128,038	136,645		136,645		136,645			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,488,318	101,976	964,611	2,554,905		2,554,905		2,554,905			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Galena Stauss Nursing Home# 0049718

Report Period Beginning:

10/01/15

Ending:

9/30/16

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/15 Ending: 9/30/16

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)	0	0	0	0	0	0	0	0	0	0	0	0	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

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

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 9/30/16

Fax Number

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			X	Construction of New Hospital		10/01/06	\$ 45,485,000	\$ 43,945,000	10/01/2046	6.7500	\$ 9,531	1	
2				Administration is located in								2	
3				new facility. Interest reported								3	
4				relates to the NH's portion of								4	
5				the administrative offices.								5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 45,485,000	\$ 43,945,000			\$ 9,531	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 45,485,000	\$ 43,945,000			\$ 9,531	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.) SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

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.

IL478-2471

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Galena Stauss Nursing Home COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 0049718

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 2015 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 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

19,191

B. General Construction Type:

Exterior Brick

Frame Blcok

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1					\$		1
2							2
3	TOTALS				\$		3

SEE ACCOUNTANTS' PREPARATION REPORT

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	57			1971	\$ 172,407	\$		\$		\$ 172,407	4
5				1981	57,844					57,844	5
6				1988	171,482	4,287	25	4,287		155,544	6
7				2007	847,453	6,831	40	6,831		315,509	7
8											8
	Improvement Type**										
9	PARKING LOT EXPAN.			04/01/81	7,150	-	12	-		7,150	9
10	PARKING LOT			06/01/00	25,239	1,122	15	1,122		25,169	10
11	2 TREES			03/31/02	132	7	20	7		96	11
12	HANDICAP ENTRANCE			03/31/02	739	49	15	49		714	12
13	REPAIR TO SIDEWALK (CLINIC/NH)			03/31/02	1,136	76	15	76		1,098	13
14	LANDSCAPING & PARKING LOT			06/01/00	39,208	1,743	15	1,743		39,099	14
15	2 TREES			03/31/02	75	4	20	4		55	15
16	STOREROOM			04/01/70	11,787	-	42	-		11,787	16
17	STOREROOM & MTC-GENERAL			04/01/75	35,868	-	34	-		35,868	17
18	STOREROOM & MTC-ELECTRICAL			04/01/75	3,825	-	20	-		3,825	18
19	STOREROOM & MTC-MECHANICAL			04/01/75	8,222	-	25	-		8,222	19
20	GENERAL CONTRACT			04/01/85	32,281	-	24	-		32,281	20
21	ELECTRICAL			04/01/85	19,623	-	20	-		19,623	21
22	MECHANICAL			04/01/85	29,729	-	20	-		29,729	22
23	MILLWORK			04/01/85	11,688	-	20	-		11,688	23
24	NEW ROOM-GIESE			04/01/86	11,426	-	10	-		11,426	24
25	MILLWORK-BLDG ADD'N			05/01/88	5,952	-	20	-		5,927	25
26	PLUMBING-BLDG ADD'N			05/01/88	24,990	-	20	-		24,885	26
27	HEATING & A/C-BLDG ADD'N			05/01/88	24,438	-	20	-		24,336	27
28	ELECTRICAL-BLDG ADD'N			05/01/88	29,353	-	20	-		29,230	28
29	AIR CONDITIONING REPLACEMENT			04/01/89	8,507	-	10	-		8,507	29
30	BOILER REPLACEMENT			04/01/89	21,149	-	20	-		21,149	30
31	ELECTRICAL-RADIOLOGY REMODEL			04/01/96	13,502	-	18	-		13,502	31
32	GENERAL-RADIOLOGY REMODELING			04/01/96	31,216	780	20	780		31,216	32
33	PHYSICAL THERAPY ROOM REMODEL			04/01/97	4,169	208	20	208		4,065	33
34	REBUILD CHILLER			04/01/99	3,666	-	10	-		3,666	34
35	ARMSTRONG TILE FLOORING FOR DIETARY			04/01/00	1,287	64	20	64		1,062	35
36	FIRE ALARM SYSTEM-ADMINISTRATION			04/01/01	905	30	15	30		905	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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

0049718

Report Period Beginning:

10/01/15

Ending:

9/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 REMODELING-BUSINESS OFFICE	04/01/01	\$ 63,452	\$ 2,115	15	\$ 2,115	\$	\$ 63,452	37
38 HOOD & EXHAUST WORK - DIETARY	04/01/01	907	45	20	45		703	38
39 RADIOLOGY REMODEL	03/31/02	23,995	1,600	15	1,600		23,196	39
40 NURSING HOME NEW CEILING	03/31/02	2,789	-	10	-		2,789	40
41 NURSING HOME SHOWER FLOORS	03/31/02	471	24	20	24		342	41
42 NURSING HOME REMODEL	11/04/02	3,088	-	10	-		3,088	42
43 NURSING HOME THERMOSTATS & ELECTRIC	01/09/03	2,428	-	10	-		2,428	43
44 AUTOMATIC ENTRANCE MED-SURG	01/28/03	7,501	-	5	-		7,501	44
45 ADMINISTRATION REMODEL	03/26/03	5,491	366	15	366		4,941	45
46 HOSPITAL GENERATOR POWER SOURCE	03/31/03	4,990	-	5	-		4,990	46
47 ELECTRICAL WORK	10/31/03	3,736	187	20	187		2,335	47
48 DENSITOMETER ROOM	03/31/04	4,102	-	5	-		4,102	48
49 CIRCULATING BOOSTER PUMP	04/30/04	2,708	-	10	-		2,708	49
50 PT REMODEL	05/01/04	8,044	536	15	536		6,703	50
51 CT REMODEL	05/20/05	58,451	2,923	20	2,923		33,609	51
52 REMODELING-GENERAL	04/01/94	52,851	1,957	27	1,957		44,042	52
53 PLUMBING	04/01/94	4,680	-	20	-		4,680	53
54 HEATING,VENTING,AIR COND.	04/01/94	11,049	-	20	-		11,049	54
55 ELECTRICAL	04/01/94	21,537	-	20	-		21,537	55
56 SUSPENDED CEILING	04/01/94	2,919	-	12	-		2,919	56
57 CABINETS	04/01/94	7,332	-	20	-		7,332	57
58 FLOOR COVERINGS	04/01/94	4,840	-	10	-		4,840	58
59 ELEVATOR	04/01/94	11,876	-	20	-		11,876	59
60 HAND RAIL FOR PHYSICAL THERAPY	12/17/02	303	20	15	20		273	60
61 ELEVATOR PROCESSOR BOARD	12/01/05	981	-	5	-		972	61
62 ER REMODEL/SHOWER ROOM	01/01/06	1,671	111	15	111		1,193	62
63 GARAGE DOOR	07/01/06	436	33	10	33		434	63
64 FLOORING	09/22/06	233	12	10	12		233	64
65 HEATING	09/30/07	2,126	142	15	142		1,346	65
66 SPRINKLER SYSTEM	09/30/07	22,634	905	25	905		8,601	66
67 SPRINKLER SYSTEM	09/30/07	2,220	89	25	89		844	67
68 HVAC UNIT	09/30/07	7,044	470	15	470		4,461	68
69 PLASTIC CULVERT PIPE	09/30/07	1,470	74	20	74		698	69
70 TOTAL (lines 4 thru 69)		\$ 2,004,798	\$ 26,809		\$ 26,809	\$	\$ 1,397,799	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home

0049718

Report Period Beginning:

10/01/15

Ending:

9/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,004,798	\$ 26,809		\$ 26,809		\$ 1,397,799	1
2 Building Components/Remodeling - 2007 Nursing Home	12/05/07	1,381	69	20	69		610	2
3 Deck	09/30/10	4,998	500	10	500		3,249	3
4 Flooring	09/30/10	421	42	10	42		273	4
5 Windows and Doors	09/30/10	5,307	265	20	265		1,725	5
6 Landscaping	12/02/11	738	105	7	105		475	6
7 Replace Flat Roof at NH	10/24/11	48,500	4,850	10	4,850		21,825	7
8 Replace Kitchen Ceiling in NH	11/16/11	2,358	236	10	236		1,061	8
9 Carpet and Flooring - Resident Rooms in NH	07/13/12	6,802	1,360	5	1,360		6,122	9
10 Flooring - Vinyl - NH Dining Room and Nurses Station	07/13/12	3,892	389	10	389		1,751	10
11 Resident Room Faucets in NH Patient Rooms	11/23/12	2,098	105	20	105		367	11
12 Resident Room Vanity Countertops in NH Patient Rooms	12/30/12	1,146	76	15	76		267	12
13 Flashed Roof Top Duct Work on NH Building	05/30/13	477	48	10	48		167	13
14 Flooring	04/08/15	3,176	318	10	318		476	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 TOTAL (lines 1 thru 33)		\$ 2,086,089	\$ 35,172		\$ 35,172		\$ 1,436,166	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$442,955	\$19,189	\$19,189	\$		\$184,884	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	36,145					36,145	73
74								74
75	TOTALS	\$479,100	\$19,189	\$19,189	\$		\$221,029	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$2,565,189	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$54,361	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$54,361	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)	\$1,657,195	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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?
16. Rental Amount for movable equipment: \$5,609 Description: Copier and special single use equipment for residents (oxygen canisters, equipment, etc.)
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

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

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

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)	\$			

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	

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	Line 39 col. 1	56 hrs	8,607				56	8,607	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy		# of prescrpts							9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
	Academic Education		hrs							11					
12	Other (specify):									12					
13	Other (specify):									13					
14	TOTAL			\$ 8,607		\$	\$	56	\$ 8,607	14					

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 1,873,016	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,414,992)	4,325,200		3
4	Supply Inventory (priced at)	359,938		4
5	Short-Term Investments	1,933,076		5
6	Prepaid Insurance	288,084		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other receivables	104,160		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,883,474	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,261,928		12
13	Land	448,597		13
14	Buildings, at Historical Cost	42,153,875		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,400,058		16
17	Accumulated Depreciation (book methods)	(25,476,183)		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 (spe Gift Fund	10,983		22
23	Other(specify):	755,449		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 34,554,707	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 43,438,181	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 635,455	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	565,407		29
30	Accrued Salaries Payable	550,215		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,483,076		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Amounts payable to Medicare	25,000		36
37	Security deposits and deferred revenue	360,782		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,619,935	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,968		39
40	Mortgage Payable			40
41	Bonds Payable	43,519,647		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred revenue	928,141		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 44,526,756	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,146,691	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,708,510)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 43,438,181	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,037,871)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,037,871)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	348,441	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) Interest Income	12,387	15
16	Other (describe) Loans forgiven from temp restricted net assets	(31,467)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 329,361	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)	\$ (4,708,510)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

0049718

Report Period Beginning: 10/01/15

Ending:

9/30/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,222,499	1
2	Discounts and Allowances for all Levels	(1,414,145)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,808,354	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	Hospital net income	94,992	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 94,992	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,903,346	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	489,261	31
32	Health Care	1,384,117	32
33	General Administration	480,990	33
	B. Capital Expense		
34	Ownership	63,892	34
	C. Ancillary Expense		
35	Special Cost Centers	8,607	35
36	Provider Participation Fee	128,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,554,905	40
41	Income before Income Taxes (line 30 minus line 40)**	348,441	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 348,441	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,211,810	44
45	Private Pay - Net Inpatient Revenue	1,569,238	45
46	Medicare - Net Inpatient Revenue	27,306	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,808,354	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,285	\$ 82,653	\$ 36.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,918	4,303	110,397	25.66	3
4	Licensed Practical Nurses	9,370	10,291	220,215	21.40	4
5	CNAs & Orderlies	39,188	43,042	540,989	12.57	5
6	CNA Trainees					6
7	Licensed Therapist	108	118	4,293	36.38	7
8	Rehab/Therapy Aides	3,132	3,440	33,504	9.74	8
9	Activity Director	2,120	2,329	30,357	13.03	9
10	Activity Assistants	1,608	1,766	19,596	11.10	10
11	Social Service Workers	1,733	1,903	32,347	17.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,843	8,932	106,677	11.94	15
16	Dishwashers					16
17	Maintenance Workers	1,358	1,371	26,241	19.14	17
18	Housekeepers	4,132	4,174	48,711	11.67	18
19	Laundry					19
20	Administrator	1,231	1,353	51,074	37.75	20
21	Assistant Administrator	1,152	1,265	46,384	36.67	21
22	Other Administrative	1	1	12	12.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,073	2,277	30,062	13.20	31
32	Other Health Care Physical Therapist	338	343	8,607	25.09	32
33	Other(specify)Allocated Admin	1,542	1,542	96,199	62.39	33
34	TOTAL (lines 1 - 33)	83,927	90,735	\$ 1,488,318 *	\$ 16.40	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Tracy Bauer	CEO		\$ 17,533
Carrie Temperly	NH DON - OLD		35,787
Jennifer Trebian	NH DON - NEW		13,104
Amounts are allocated - see separate cost report for allocation to AL and ADL			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,424
B. Administrative - Other			
Description			Amount
Supplies and allocated administrative expenses			\$ 43,227
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 43,227
C. Professional Services			
Vendor/Payee	Type		Amount
			\$
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$
Unemployment Compensation Insurance			
FICA Taxes			
Employee Health Insurance			
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Allocated benefits from Medicare cost report			341,564
TOTAL (agree to Schedule V, line 22, col.8)			\$ 341,564
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
Less: Public Relations Expense			()
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name & ID Number		Galena Stauss Nursing Home		STATE OF ILLINOIS	#	0049718	Report Period Beginning:	10/01/15	Ending:	9/30/16	Page 22
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? 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? What was the average life used for new equipment added during this period?			Yes 7							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ 56,242 Line 15							
(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? 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.			\$ 123,038							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.										
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			Yes							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.			\$ 0		Has any meal income been offset against related costs? Yes			Indicate the amount. \$ 89,622		
(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? No If YES, please indicate the amount of income earned from such a program during this reporting period.			\$							
	c. What percent of all travel expense relates to transportation of nurses and patients?			0							
	d. Have vehicle usage logs been maintained?			N/A							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			N/A							
	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:			Yes Wipfli, LLP							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			Yes							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees			N/A		N/A for details legal fees related to the NH in 2016					

SEE ACCOUNTANTS' PREPARATION REPORT