

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

<p>I. IDPH License ID Number: <u>0039149</u></p> <p>Facility Name: <u>BJORKLUND HOUSE</u></p> <p>Address: <u>15841 TERRACE DRIVE</u> <u>OAK FOREST</u> <u>60452</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(708) 687-2038</u> Fax # <u>(708) 687-2762</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/24/1994</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>NAWARA FINANCIAL ADVISORS INC</u> Telephone Number: <u>(708) 447-7100</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2009</u> to <u>06/30/2010</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>JULIE SMITH</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>MARK MERMAN CPA</u></td> </tr> <tr> <td>(Firm Name & Address) <u>NAWARA FINANCIAL ADVISORS INC</u> <u>7420 WEST COLLEGE DRIVE, PALOS HEIGHTS, IL</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(708) 448-7100</u> Fax # <u>(708) 448-5521</u></td> </tr> <tr> <td></td> <td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>JULIE SMITH</u> (Date) _____		(Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>MARK MERMAN CPA</u>	(Firm Name & Address) <u>NAWARA FINANCIAL ADVISORS INC</u> <u>7420 WEST COLLEGE DRIVE, PALOS HEIGHTS, IL</u>		(Telephone) <u>(708) 448-7100</u> Fax # <u>(708) 448-5521</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number BJORKLUND HOUSE

0039149 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 16

	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	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,779			5,779	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,779			5,779	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.96%

D. How many bed-hold days during this year were paid by the Department? 122 (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 01/12/1994

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1993 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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 07/01/2009 Fiscal Year: 06/30/2010

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

Facility Name & ID Number **BJORKLUND HOUSE** # **0039149** Report Period Beginning: **07/01/2009** Ending: **06/30/2010**

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	25,616		5,940	31,556		31,556		31,556		1
2	Food Purchase		45,603		45,603		45,603		45,603		2
3	Housekeeping		3,165	19,054	22,219		22,219		22,219		3
4	Laundry										4
5	Heat and Other Utilities			16,785	16,785		16,785		16,785		5
6	Maintenance	10,756	5,321	5,228	21,305		21,305		21,305		6
7	Other (specify):*										7
8	TOTAL General Services	36,372	54,089	47,007	137,468		137,468		137,468		8
	B. Health Care and Programs										
9	Medical Director			4,990	4,990	(4,990)					9
10	Nursing and Medical Records	301,369	5,315	49,243	355,927	(5,400)	350,527		350,527		10
10a	Therapy			13,857	13,857		13,857		13,857		10a
11	Activities		1,225	10,349	11,574		11,574		11,574		11
12	Social Services	62,525		1,540	64,065		64,065		64,065		12
13	CNA Training					5,400	5,400		5,400		13
14	Program Transportation			3,934	3,934	(3,934)					14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	363,894	6,540	83,913	454,347	(8,924)	445,423		445,423		16
	C. General Administration										
17	Administrative	28,237		2,939	31,176		31,176		31,176		17
18	Directors Fees										18
19	Professional Services			20,184	20,184		20,184		20,184		19
20	Dues, Fees, Subscriptions & Promotions			4,504	4,504		4,504	(2,381)	2,123		20
21	Clerical & General Office Expenses	27,290	7,776	7,684	42,750		42,750		42,750		21
22	Employee Benefits & Payroll Taxes			113,233	113,233		113,233		113,233		22
23	Inservice Training & Education			747	747		747		747		23
24	Travel and Seminar			403	403		403		403		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			16,713	16,713	(4,086)	12,627		12,627		26
27	Other (specify):*										27
28	TOTAL General Administration	55,527	7,776	166,407	229,710	(4,086)	225,624	(2,381)	223,243		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	455,793	68,405	297,327	821,525	(13,010)	808,515	(2,381)	806,134		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			46,265	46,265		46,265	(10,357)	35,908			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,175	17,175		17,175	(593)	16,582			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			63,440	63,440		63,440	(10,950)	52,490			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					13,010	13,010		13,010			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,380	49,380		49,380		49,380			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			49,380	49,380	13,010	62,390		62,390			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	455,793	68,405	410,147	934,345		934,345	(13,331)	921,014			45

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

BJORKLUND HOUSEID# 0039149Report Period Beginning: 07/01/2009Ending: 06/30/2010

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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

Facility Name & ID Number **BJORKLUND HOUSE** # **0039149** Report Period Beginning: **07/01/2009** Ending: **06/30/2010**

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

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning:

07/01/2009

Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (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 2009 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 2010 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:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BJORKLUND HOUSE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039149

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 2009 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 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.**

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning:

07/01/2009 Ending:

06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,000 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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	<u>16-BED ICF/DD</u>	<u>24,568</u>	<u>1993</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	24,568		\$ 60,000	3

Facility Name & ID Number

BJORKLUND HOUSE

0039149

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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										
										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	National Covenant Properties	X	FIRST MORTGAGE	\$1,720.00	04/24/08	\$ 245,000	\$ 240,507	05/28/2028	0.0575	\$ 10,053	1								
2	National Covenant Properties	X	SECOND MORTGAGE		02/28/08	100,000	36,848	LOC	PRIME	6,671	2								
3	National Covenant Properties	X	write off deferred interest		01/01/99	343,919	0	12/19/2008	0.0700	215	3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$1,720.00		\$ 688,919	\$ 277,355			\$ 16,939	9								
B. Non-Facility Related*																			
10	CREDIT CARD	X	CREDIT CARD INTEREST							236	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$ 236	14								
15	TOTALS (line 9+line14)					\$ 688,919	\$ 277,355			\$ 17,175	15								

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

* 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.)

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		1993	1993	\$ 428,233	\$ 10,706	40	\$ 10,706	\$	\$ 176,017	4
5			2006	2006	462,246	11,627	40	11,627		46,991	5
6											6
7											7
8											8
	Improvement Type**										
9	Sod		1994		2,150	108	20	108		1,771	9
10	Landscaping		1994		3,441	172	20	172		2,774	10
11	Fence		1994		719	36	20	36		573	11
12	Landscaping		1994		998	50	20	50		791	12
13	Sidewalk		1997		1,566	78	20	78		977	13
14	Landscaping		1997		4,545	227	20	227		2,838	14
15	Landscaping		2006		15,839	792	20	792		2,739	15
16	Plumbing		1994		250		15			250	16
17	Insulation		1994		1,800		15			1,800	17
18	Sprinklers		1994		150		15			150	18
19	Stairway Lighting		1994		345		15			345	19
20	Drywalling		1994		264		15			264	20
21	Garage		1994		8,421	421	20	421		6,612	21
22	Water Heater		1995		3,736	129	15	129		3,736	22
23	Valve/Water Heater		1996		1,900		8			1,900	23
24	Laundry Tub		1996		1,985		8			1,985	24
25	Enclose Porch		1996		1,606		8			1,606	25
26	Septic System		1997		2,268		8			2,268	26
27	Steel Door Frames		1997		3,840		8			3,840	27
28	Sprinkler System		2000		2,880	192	15	192		1,824	28
29	Carpeting		2001		4,050		8			4,050	29
30	Curtains		2001		1,968		8			1,968	30
31	Painting		2001		1,380		8			1,380	31
32	Air Conditioning		2001		2,600		8			2,600	32
33	Painting		2002		590	35	8	35		590	33
34	Sump Pump		2002		189	10	8	10		189	34
35	Air Conditioning		2001		2,450	155	8	155		2,450	35
36	Carpeting		2002		350	44	8	44		330	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 Depreciation-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	New Pumps	2002	\$ 1,637	\$ 205	8	\$ 205	\$	\$ 1,537	37
38	Water Heater	2002	3,925	491	8	491		3,682	38
39	New Valve-Fire/Sprinkler System	2002	1,245	156	8	156		1,170	39
40	Ceramic Tile for Bathroom	2004	409	27	15	27		149	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)		\$ 969,975	\$ 25,661		\$ 25,661	\$	\$ 282,146	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 80,375	\$ 9,963	\$ 9,963	\$		\$ 51,410	71
72	Current Year Purchases	1,838	115	115			115	72
73	Fully Depreciated Assets	8,912	0	0			8,912	73
74								74
75	TOTALS	\$ 91,125	\$ 10,078	\$ 10,078	\$		\$ 60,437	75

D. Vehicle Depreciation (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)	\$ 1,121,100	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,739	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,739	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)	\$ 342,583	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	LAND AND BUILDING	\$ 389,420	\$ 9,570	\$ 109,441	86
87	FURNITURE AND EQUIPMENT	17,018	1,383	7,788	87
88	VEHICLE - BJ	89,501	10,357	63,610	88
89	VEHICLE - IP	26,291	5,258	13,145	89
90					90
91	TOTALS	\$ 522,230	\$ 26,568	\$ 193,984	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		3,600		3,600
4	Clinical Wages (b)		1,800		1,800
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,400	\$	\$ 5,400
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,400		

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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

- (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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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.

Facility Name & ID Number **BJORKLUND HOUSE**# **0039149**Report Period Beginning: **07/01/2009**Ending: **06/30/2010****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2010**

(last day of reporting year)

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	\$ 170,368	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	617,444		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,362		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)	\$ 793,174	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	110,000		13
14	Buildings, at Historical Cost	1,309,395		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	223,934		16
17	Accumulated Depreciation (book methods)	(536,566)		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)	\$ 1,106,763	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,899,937	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 268,176	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,825		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	233		33
34	Deferred Compensation			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)	\$ 313,234	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	363,502		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)	\$ 363,502	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 676,736	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,223,201	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,899,937	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,129,846	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,129,846	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,998	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) FUNDRAISING	37,214	15
16	Other (describe) SEPARATE DHS PROGRAM	51,143	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 93,355	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)	\$ 1,223,201	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BJORKLUND HOUSE**

0039149

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 902,320	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 902,320	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	36,547	24
25	Interest and Other Investment Income***	357	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,904	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	119	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 119	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 939,343	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	137,468	31
32	Health Care	454,347	32
33	General Administration	229,710	33
B. Capital Expense			
34	Ownership	63,440	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	49,380	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 934,345	40
41	Income before Income Taxes (line 30 minus line 40)**	4,998	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,998	43

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

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

Facility Name & ID Number **BJORKLUND HOUSE**

0039149

Report Period Beginning: **07/01/2009**

Ending:

06/30/2010

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		1,137	33,829	29.75	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers		1,040	28,689	27.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook		2,161	25,616	11.85	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers		1,024	10,756	10.50	17
18	Housekeepers					18
19	Laundry					19
20	Administrator		1,040	28,688	27.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical		1,495	27,290	18.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		2,080	33,384	16.05	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)		24,888	267,541	10.75	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		34,865	\$ 455,793 *	\$ 13.07	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		4,990	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		450	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		11,932	L10a,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		1,925	L10a,C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>DENTAL</u>		6,668	L10,C3	46
47	<u>PSYCHOLOGIST/PHYCHIATRIST</u>		5,633	L10,C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,598		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership			D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	\$	Description	Amount	Description		
				\$			Amount		
					Workers' Compensation Insurance	\$ 30,333	IDPH License Fee	\$	
					Unemployment Compensation Insurance	4,583	Advertising: Employee Recruitment		
					FICA Taxes	30,524	Health Care Worker Background Check		
					Employee Health Insurance	45,456	(Indicate # of checks performed _____)	128	
					Employee Meals		Patient Background Checks		
					Illinois Municipal Retirement Fund (IMRF)*		Various Dues and Fees	4,376	
					Staff Goodwill	2,465			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$			Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	()	
	Description		Amount				Yellow page advertising	()	
	BANK CHARGES		85	\$					
	VARIOUS MISCELLANEOUS CHARGES		2,854						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	TOTAL (agree to Schedule V, line 22, col.8)		\$	TOTAL (agree to Sch. V, line 20, col. 8)	
				2,939	\$	113,361	4,504		
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
	Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
	Nawara Financial Advisors	Accounting	11,061	\$				Out-of-State Travel	\$
	The Condon Group LTD	Payroll Services	3,138						
	ADP/C.M.B./	Audit Fees	5,888					In-State Travel	403
	C.M.B.	Legal Fees	97						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$	TOTAL		\$	Seminar Expense	
				20,184				Entertainment Expense	()

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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. N/A
- (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? 8 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,735 Line L10,C3
- (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. \$ 49,380
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. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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? N/A
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: ROCHE, SCHOLZ, ROCHE & WALSH LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name and ID #: BJORKLUND HOUSE # 0039149
 Period: 7/1/2009 - 6/30/2010

Schedule of Reclassifications - Schedule V - Page 3 and page 4

<u>Description</u>				
Medical Director	4,990	Reclass from Medical Director to Ancillary Service Centers	From To	Line 9 Line 39
Nursing and Medical Records	5,400	Reclass from Nursing and Medical Records to CNA Training	From To	Line 10 Line 13
Program Transportation	3,934	Reclass from Program Transportation to Ancillary Service Centers	From To	Line 14 Line 39
Vehicle Insurance (Day Training)	4,086	Reclass from Insurance-Prop Liab to Ancillary Service Centers	From To	Line 26 Line 39

Reconciliation of Taxable Income - Schedule XVII, Line 43

Schedule XVII Line 43 - Net Income Loss for the Year	4,998
Net income from Separate DHS program	37,214
Fundraising Income	<u>51,143</u>
Income reported on Federal tax return	<u><u>93,355</u></u>

Facility Name and ID #: BJORKLUND HOUSE # 0039149
Period: 7/1/2009 - 6/30/2010

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Question (12) - Schedule XX General Questions

Salary costs are allocated to more than one line when an employee performs more than one function.

Listing of Board of Directors

Harold Spooner
President of C.E.R. of Illinois Board
6015 N. Mozart
Chicago, IL 60659

Donna Frownfelter
Board Member
3349 Ralmark Lane
Glenview, IL 60026

David A. Dwight
Staff Advisory
15841 Terrace Drive
Oak Forest, IL 60452

Jeff Heise
Chairman
526 Amy Lane
Wheaton, IL 60187

Cindy Hallett
Board Member
408 Sherman Street
West Chicago, IL 60185

Julie Smith
Staff Advisory
15841 Terrace Drive
Oak Forest, IL 60452

Sue Eade
Secretary
15225 S. Hillside Avenue
Oak Forest, IL 60452

Tom Olson
Board Member
127 Jeffery Lane
Des Plaines, IL 60018

Peter Berghoff
Treasurer
8855 S. Hamilton Avenue
Chicago, IL 60620

Judy Yost
Board Member
3145 Ewlder Ct
Northbrook, IL 60062