

		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><b>I. IDPH License ID Number:</b> <u>0032128</u></p> <p><b>Facility Name:</b> <u>Carolyn Smith House</u></p> <p><b>Address:</b> <u>910 17th Street</u> <u>Charleston</u> <u>61920</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Coles</u></p> <p><b>Telephone Number:</b> <u>(217) 345-2922</u> <b>Fax #</b> <u>(217) 398-0944</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/16/87</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Sherry Newton</u> <b>Telephone Number:</b> <u>(217) 398-0754</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/09</u> to <u>9/30/10</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Sherry Newton</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) <u>See Attached Compilation Report</u>            (Print Name and Title) <u>James B. Eisenmenger, MS, CPA</u>  <u>Member</u>            (Firm Name &amp; Address) <u>Martin, Hood, Friese &amp; Associates, LLC</u>  <u>2507 S. Neil Street, Champaign, IL 61820</u>            (Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b> </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Sherry Newton</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) <u>See Attached Compilation Report</u> (Print Name and Title) <u>James B. Eisenmenger, MS, CPA</u> <u>Member</u> (Firm Name & Address) <u>Martin, Hood, Friese &amp; Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u> (Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Sherry Newton</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) <u>See Attached Compilation Report</u> (Print Name and Title) <u>James B. Eisenmenger, MS, CPA</u> <u>Member</u> (Firm Name & Address) <u>Martin, Hood, Friese &amp; Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u> (Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House

# 0032128 Report Period Beginning: 10/01/09 Ending: 9/30/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	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	Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,726			5,726	13
14	TOTALS	5,726			5,726	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.05%

D. How many bed-hold days during this year were paid by the Department? 114 (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 04/16/87

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/16/87 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/10 Fiscal Year: 9/30/10

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

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/09 Ending: 9/30/10

**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
	<b>A. General Services</b>										
1	Dietary	32,519		1,260	33,779		33,779		33,779		1
2	Food Purchase		32,392		32,392		32,392		32,392		2
3	Housekeeping	26,015	5,527		31,542		31,542	48	31,590		3
4	Laundry	13,008	1,103		14,111		14,111		14,111		4
5	Heat and Other Utilities			17,515	17,515		17,515	1,856	19,371		5
6	Maintenance			25,004	25,004		25,004	12,500	37,504		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	71,542	39,022	43,779	154,343		154,343	14,404	168,747		8
	<b>B. Health Care and Programs</b>										
9	Medical Director		2,828	3,000	5,828		5,828		5,828		9
10	Nursing and Medical Records	86,314	205	16,293	102,812		102,812	(3,444)	99,368		10
10a	Therapy										10a
11	Activities	13,008	3,191		16,199		16,199		16,199		11
12	Social Services										12
13	CNA Training	3,208			3,208		3,208		3,208		13
14	Program Transportation			2,197	2,197		2,197	1,462	3,659		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	102,530	6,224	21,490	130,244		130,244	(1,982)	128,262		16
	<b>C. General Administration</b>										
17	Administrative	37,668		99,796	137,464		137,464	(60,154)	77,310		17
18	Directors Fees							415	415		18
19	Professional Services			4,554	4,554		4,554	2,181	6,735		19
20	Dues, Fees, Subscriptions & Promotions			2,204	2,204		2,204	444	2,648		20
21	Clerical & General Office Expenses	13,008	592	4,745	18,345		18,345	12,955	31,300		21
22	Employee Benefits & Payroll Taxes			48,831	48,831		48,831	13,361	62,192		22
23	Inservice Training & Education			113	113		113	85	198		23
24	Travel and Seminar							407	407		24
25	Other Admin. Staff Transportation			941	941		941	4,262	5,203		25
26	Insurance-Prop.Liab.Malpractice			6,258	6,258		6,258	1,907	8,165		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	50,676	592	167,442	218,710		218,710	(24,137)	194,573		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	224,748	45,838	232,711	503,297		503,297	(11,715)	491,582		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Carolyn Smith House

#0032128

Report Period Beginning:

10/01/09

Ending:

9/30/10

## 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			6,051	6,051		6,051	8,150	14,201			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,575	1,575		1,575	7,638	9,213			32
33	Real Estate Taxes			2,149	2,149		2,149	2,263	4,412			33
34	Rent-Facility & Grounds			45,900	45,900		45,900		45,900			34
35	Rent-Equipment & Vehicles			50	50		50	470	520			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			55,725	55,725		55,725	18,521	74,246			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,285	40,285		40,285		40,285			42
43	Other (specify):* <b>IL Repl Tax</b>			1,290	1,290		1,290	(1,290)				43
44	<b>TOTAL Special Cost Centers</b>			41,575	41,575		41,575	(1,290)	40,285			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	224,748	45,838	330,011	600,597		600,597	5,516	606,113			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,290)	43-3		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,290)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule <b>Schedule VIII</b>	6,806		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 6,806		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 5,516		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Carolyn Smith House

ID# 0032128  
 Report Period Beginning: 10/01/09  
 Ending: 9/30/10

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
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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	<b>Total</b>	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
See Schedule VII C		See Attached Schedule		Health Services Consul	Champaign, IL	Consulting
				Cobblestone Rehabilita	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long-Term Care
				The Residential Develo	Champaign, IL	Long-Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

**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	See Schedule VIII	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Carolyn Smith House

#

0032128

Report Period Beginning:

10/01/09

Ending:

9/30/10

## 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	Alan Ryle	Chairman	Administrative	0.60	All related party wages are allocations from			Administrative	\$ 1,159	17-7	1
2	Lynn Ryle	Director	Administrative	0.00	HSC. See attached allocation spreadsheet			Administrative	1,159	17-7	2
3	Patti Hood			0.35	and explanation. These individuals receive						3
4	Sherry Newton	CEO	Administrative	0.05	no compensation from entities other			Administrative	10,887	17-7	4
5					than HSC.						5
6	Alan Ryle	Chairman	Directors Fees	0.60				Directors Fees	207	18-7	6
7	Lynn Ryle	Director	Directors Fees	0.00				Directors Fees	208	18-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,620		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House

# 0032128

Report Period Beginning:

10/01/09

Ending: 9/30/10

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 Health Services Consultants, Inc.  
 Street Address P.O. Box 3037  
 City / State / Zip Code Champaign, IL 61826  
 Phone Number ( 217) 398-0754  
 Fax Number ( 217) 398-0944

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	10	Nursing	Reverse actual amounts paid and accrued to HSC for		\$	\$		(8,803)	1
2	17	Administrative	services provided in order to allocate HSC's actual expenses.					(99,796)	2
3									3
4	3	Housekeeping	Beds	370	207	1,110	16	48	4
5	5	Heat & Utilities	Beds	370	207	42,909	16	1,856	5
6	6	Maintenance	Beds	370	207	267,766	16	12,500	6
7	10	Nursing	Beds	370	207	192,582	16	5,359	7
8	14	Program Transportation	Beds	370	207	33,812	16	1,462	8
9	17	Administrative	Beds	370	207	950,956	16	39,642	9
10	18	Director Fees	Beds	370	207	9,600	16	415	10
11	19	Professional Fees	Beds	370	207	50,435	16	2,181	11
12	20	Dues & Subscriptions	Beds	370	207	10,279	16	444	12
13	21	Clerical	Beds	370	207	297,827	16	12,955	13
14	22	P/R Taxes & Benefits	Beds	370	207	523,534	16	13,361	14
15	23	Inservice	Beds	370	207	1,963	16	85	15
16	24	Travel & Seminar	Beds	370	207	9,410	16	407	16
17	25	Administrative Transportation	Beds	370	207	98,562	16	4,262	17
18	26	Insurance	Beds	370	207	44,102	16	1,907	18
19	30	Depreciation	Beds	370	207	188,461	16	8,150	19
20	32	Interest	Beds	370	207	176,631	16	7,638	20
21	33	Real Estate Tax	Beds	370	207	52,340	16	2,263	21
22	35	Equipment Lease	Beds	370	207	10,860	16	470	22
23	N/A	Salaries and Wages	Beds	370	207	959,105	16	0	23
24									24
25	TOTALS				\$ 3,922,244	\$ 2,535,094		\$ 6,806	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Carolyn Smith House

# 0032128

Report Period Beginning:

10/01/09

Ending:

9/30/10

**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		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
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	<b>Working Capital</b>																		
6	Busey Bank		X	Working Capital	N/A	11/1/2009	N/A		11/30/2010	5.0000	1,575	6							
7	Shchedule VIII Allocation		X								7,638	7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 9,213	9							
	<b>B. Non-Facility Related*</b>																		
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 9,213	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' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																						
1. Real Estate Tax accrual used on 2009 report.		\$	<b>4,766</b>	<b>1</b>																				
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.)		\$	<b>4,195</b>	<b>2</b>																				
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(571)</b>	<b>3</b>																				
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>2,720</b>	<b>4</b>																				
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>																				
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>2,149</b>	<b>7</b>																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2005	<b>4,626</b>	<b>8</b>	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;"><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>13</b></td> </tr> <tr> <td style="text-align: center;"><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>14</b></td> </tr> <tr> <td style="text-align: center;"><b>15</b></td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>15</b></td> </tr> <tr> <td style="text-align: center;"><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>16</b></td> </tr> </table>		<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
<b>FOR BHF USE ONLY</b>																								
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009	\$	<b>13</b>																					
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																					
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																					
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																					
	2006	<b>4,274</b>	<b>9</b>																					
	2007	<b>4,137</b>	<b>10</b>																					
	2008	<b>4,186</b>	<b>11</b>																					
	2009	<b>4,195</b>	<b>12</b>																					
<b>Real estate tax accrual is based on estimated 2010 tax</b>																								

**NOTES:**

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

# 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carolyn Smith House COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0032128

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

**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.	<u>02-1-04352-000</u>	<u>Facility</u>	\$ <u>3,946.00</u>	\$ <u>3,946.00</u>
2.	<u>02-1-04351-000</u>	<u>Facility</u>	\$ <u>249.00</u>	\$ <u>249.00</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>
<b>TOTALS</b>			\$ <u><u>4,195.00</u></u>	\$ <u><u>4,195.00</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 Carolyn Smith House

# 0032128

Report Period Beginning:

10/01/09

Ending:

9/30/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 4,200 B. General Construction Type: Exterior Wood 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).

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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' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House

# 0032128

Report Period Beginning:

10/01/09

Ending:

9/30/10

**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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Leasehold Improvements	1993		12,864	378	34	378		6,645	9
10	Leasehold Improvements	1995		4,775	177	27	177		2,745	10
11	Window Treatments	1997		7,428	275	27	275		3,895	11
12	Flooring	1998		6,670	247	27	247		3,148	12
13	Flooring	1998		2,030	75	27	75		944	13
14	Alarm System Upgrade	1998		4,356	161	27	161		1,992	14
15	Furnace	2001		1,650	165	10	165		1,598	15
16	Fire Alarm System	2004		4,287		5			4,287	16
17	Water heater	2005		1,131	162	7	162		898	17
18	Siding & Soffit	2005		13,865	504	27.5	504		2,964	18
19	Tile Floor	2005		781	61	5	61		781	19
20	Wood Flooring	2009		4,675	935	5	935		935	20
21	Kitchen Cabinets	2009		4,783	683	7	683		683	21
22	Kitchen Remodel	2010		1,700	62	27.5	62		62	22
23	Flooring	2010		1,138	228	5	228		228	23
24	Remodel Hall Bath	2010		1,519	55	27.5	55		55	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

\*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' COMPILATION REPORT



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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 73,652		\$ 4,168	\$ 4,168	\$ 31,860	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Carolyn Smith House

# 0032128

Report Period Beginning:

10/01/09

Ending:

9/30/10

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	\$ 16,300	\$ 1,661	\$ 1,661		5/7	\$ 11,182	71
72	Current Year Purchases	2,643	222	222		5/7	222	72
73	Fully Depreciated Assets	11,524					11,524	73
74								74
75	TOTALS	\$ 30,467	\$ 1,883	\$ 1,883	\$		\$ 22,928	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	Patient Transportation	1999 GMC Safari	1999	\$ 18,832	\$	\$			\$ 18,832	76
77	Patient Transportation	2002 GMC Safari	2001	22,089					22,089	77
78										78
79										79
80	TOTALS			\$ 40,921	\$	\$	\$		\$ 40,921	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)	\$ 145,040	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,051	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,051	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)	\$ 95,709	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' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Milestone Midwest, Inc.

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:	<u>1987</u>	<u>15</u>		\$ <u>45,900</u>	<u>15</u>	<u>15</u>	3
4	Additions	<u>1983</u>	<u>1</u>					4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>45,900</u>			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: N/A \*

**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: \$ 50 Description: Tool Rental

(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. Month \$ \_\_\_\_\_

13. to month lease \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* 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>40</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>80</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,069		1,069
4	Clinical Wages (b)		2,139		2,139
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 3,208	\$	\$ 3,208
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	3,208		

**C. CONTRACTUAL INCOME**

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

\$ None

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>3</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	<b>TOTAL</b>			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House

# 0032128

Report Period Beginning: 10/01/09

Ending: 9/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>4,051</u> )	164,450		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 164,600	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	73,652		15
16	Equipment, at Historical Cost	71,388		16
17	Accumulated Depreciation (book methods)	(95,709)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 49,331	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 213,931	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,194		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,720		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 13,914	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 13,914	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 200,017	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 213,931	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>218,086</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>218,086</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>136,759</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>136,759</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfers (to) from Developmental Foundations, Inc.</b>	<b>(154,828)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(154,828)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>200,017</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House# 0032128Report Period Beginning: 10/01/09Ending: 9/30/10

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 737,356	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 737,356	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 737,356	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	154,343	31
32	Health Care	130,244	32
33	General Administration	218,710	33
<b>B. Capital Expense</b>			
34	Ownership	55,725	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	40,285	36
<b>D. Other Expenses (specify):</b>			
37	<u>IL Repl Tax</u>	1,290	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 600,597	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	136,759	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 136,759	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax Return is on a 12/31 fiscal year.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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



Facility Name & ID Number Carolyn Smith House

# 0032128

Report Period Beginning:

10/01/09

Ending:

9/30/10

**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				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees	360	3,208	8.91	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	1,460	13,008	8.91	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,460	13,008	8.91	14
15	Cook Helpers/Assistants	2,190	19,511	8.91	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	2,920	26,015	8.91	18
19	Laundry	1,460	13,008	8.91	19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative	2,051	37,668	16.71	22
23	Office Manager				23
24	Clerical	1,460	13,008	8.91	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,480	29,027	17.92	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	4,949	57,287	8.91	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	19,790	224,748 *	\$ 10.40	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	\$ 1,260	1-3	35
36	Medical Director	3,000	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	8,746	10-3	38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	813	10-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	3,000	10-3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Psychologist	900	10-3	47
48	Dentist Consultant	2,073	10-3	48
49	TOTAL (lines 35 - 48)	\$ 19,792		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House

# 0032128

Report Period Beginning: 10/01/09

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**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sara Gonzalez	Other Admin	0	\$ 27,992	Workers' Compensation Insurance	\$ 11,378	IDPH License Fee	\$ 1,275	
Rachel Wojtysiak	QMRP/Admin	0	9,676	Unemployment Compensation Insurance	2,164	Advertising: Employee Recruitment	721	
				FICA Taxes	17,193	Health Care Worker Background Check		
				Employee Health Insurance	8,416	(Indicate # of checks performed <u>13</u> )	208	
				Employee Meals	6,073	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other	3,607			
				Schedule VIII Allocation	13,361	Schedule VIII Allocation	444	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 37,668	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,648		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
Management & Support Staff Fee			\$ 99,796				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 99,796	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
Martin, Hood, Friese & Associates, I	Accounting		\$ 2,201	None		\$	Out-of-State Travel \$	
Thomas, Mamer & Haughey	Legal		154					
Various	Other Prof. Services		2,199				In-State Travel	
							Schedule VIII Allocation 407	
							Seminar Expense	
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,554	TOTAL			\$ 407	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Carolyn Smith House

# 0032128

Report Period Beginning:

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Ending: 9/30/10

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IARF-\$992
- (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? N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5/7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (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. N/A
- (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. \$ 40,285  
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? None
- (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. \$ 6,073 Has any meal income been offset against related costs? No 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? Attached  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (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.

**SEE ACCOUNTANTS' COMPILATION REPORT**