

		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>0041657</u></p> <p><b>Facility Name:</b> <u>Florence Nursing Home</u></p> <p><b>Address:</b> <u>546 East Grant Highway</u> <u>Marengo</u> <u>60152</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Mchenry</u></p> <p><b>Telephone Number:</b> <u>815-568-0135</u> <b>Fax #</b> (     )</p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/15/96</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input 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><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mendel S. Schneider</u>      <b>Telephone Number:</b> <u>847-933-1274</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<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>01/01/10</u> to <u>12/31/10</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"> <tr> <td rowspan="3" style="vertical-align: middle;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4" style="vertical-align: middle;">Paid Preparer</td> <td>(Signed) <u>See Accountant's Report Attached</u></td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td colspan="2">(Firm Name &amp; Address) <u>Mendel S Schneider &amp; Associates, CPA, PC</u> <u>4556 Oakton St, Ste 200, Skokie, IL 60076</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>847-933-1274</u>      <b>Fax #</b> <u>847-933-1283</u></td> </tr> </table> <p><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>      <b>Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____		Paid Preparer	(Signed) <u>See Accountant's Report Attached</u>	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) <u>Mendel S Schneider &amp; Associates, CPA, PC</u> <u>4556 Oakton St, Ste 200, Skokie, IL 60076</u>		(Telephone) <u>847-933-1274</u> <b>Fax #</b> <u>847-933-1283</u>	
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Facility Name & ID Number Florence Nursing Home

# 0041657 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	24	Intermediate (ICF)	24	8,760	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	52	TOTALS	52	18,980	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,300	4,150	3,412	8,862	8
9	SNF/PED					9
10	ICF	1,741	6,598		8,339	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,041	10,748	3,412	17,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.63%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 04/15/96

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/15/96 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 28 and days of care provided 3,412

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name & ID Number Florence Nursing Home # 0041657 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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	129,746	8,271		138,017		138,017		138,017		1
2	Food Purchase		106,690		106,690	(3,000)	103,690		103,690		2
3	Housekeeping	24,941	5,503	4,219	34,663		34,663		34,663		3
4	Laundry	18,482	13,508		31,990		31,990		31,990		4
5	Heat and Other Utilities			70,510	70,510		70,510		70,510		5
6	Maintenance	41,144		94,340	135,484		135,484		135,484		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	214,313	133,972	169,069	517,354	(3,000)	514,354		514,354		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,700	4,700		4,700		4,700		9
10	Nursing and Medical Records	723,977	45,265	4,251	773,493		773,493		773,493		10
10a	Therapy										10a
11	Activities	29,830	1,000		30,830		30,830		30,830		11
12	Social Services			2,890	2,890		2,890		2,890		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	753,807	46,265	11,841	811,913		811,913		811,913		16
	<b>C. General Administration</b>										
17	Administrative	69,160			69,160		69,160		69,160		17
18	Directors Fees										18
19	Professional Services			43,277	43,277		43,277		43,277		19
20	Dues, Fees, Subscriptions & Promotions			32,493	32,493		32,493	(25,079)	7,414		20
21	Clerical & General Office Expenses	25,223	12,048	26,772	64,043		64,043	(8,916)	55,127		21
22	Employee Benefits & Payroll Taxes			254,456	254,456	3,000	257,456		257,456		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,211	1,211		1,211		1,211		24
25	Other Admin. Staff Transportation			9,082	9,082		9,082		9,082		25
26	Insurance-Prop.Liab.Malpractice			49,248	49,248		49,248		49,248		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	94,383	12,048	416,539	522,970	3,000	525,970	(33,995)	491,975		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,062,503	192,285	597,449	1,852,237		1,852,237	(33,995)	1,818,242		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.

Facility Name &amp; ID Number

Florence Nursing Home

#0041657

Report Period Beginning:

01/01/10

Ending:

12/31/10

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			333,928	333,928		333,928	(291,232)	42,696			30
31	Amortization of Pre-Op. & Org.							49,218	49,218			31
32	Interest							113,027	113,027			32
33	Real Estate Taxes							19,430	19,430			33
34	Rent-Facility & Grounds			216,000	216,000		216,000	(216,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			549,928	549,928		549,928	(325,557)	224,371			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			28,470	28,470		28,470		28,470			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			28,470	28,470		28,470		28,470			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,062,503	192,285	1,175,847	2,430,635		2,430,635	(359,552)	2,071,083			45

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



Florence Nursing Home

ID# 0041657

Report Period Beginning: 01/01/10

Ending: 12/31/10

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
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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Florence Nursing Home

# 0041657

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(25,079)	0	0	0	0	0	0	0	0	0	0	(25,079)	20
21	Clerical & General Office Expenses	(9,000)	84	0	0	0	0	0	0	0	0	0	(8,916)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(34,079)	84	0	0	0	0	0	0	0	0	0	(33,995)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(34,079)	84	0	0	0	0	0	0	0	0	0	(33,995)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Florence Nursing Home# 0041657

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(316,873)	25,641	0	0	0	0	0	0	0	0	0	(291,232)	30
31	Amortization of Pre-Op. & Org.	0	49,218	0	0	0	0	0	0	0	0	0	49,218	31
32	Interest	(1,155)	114,182	0	0	0	0	0	0	0	0	0	113,027	32
33	Real Estate Taxes	0	19,430	0	0	0	0	0	0	0	0	0	19,430	33
34	Rent-Facility & Grounds	0	(216,000)	0	0	0	0	0	0	0	0	0	(216,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(318,028)</b>	<b>(7,529)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(325,557)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(352,107)	(7,445)	0	0	0	0	0	0	0	0	0	(359,552)	45



**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
Joseph Brandman	71			Marengo, LLC	Marengo	Bldg Rental
David & Tamar Abell	16					
Yehudit Goldberg	5					
Moshe Brandman	8					

**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	34 Rent	\$ 216,000	The Willow of Marengo, LLC		\$	(216,000)	1
2	V	32 Interest				114,182	114,182	2
3	V	33 Real Estate Tax				19,430	19,430	3
4	V	21 Office				84	84	4
5	V	30 Depreciation				25,641	25,641	5
6	V	31 Amortization				49,218	49,218	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 216,000			\$ 208,555	\$ * (7,445)	14

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

Facility Name & ID Number Florence Nursing Home # 0041657 Report Period Beginning: 01/01/10 Ending: 12/31/10

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									\$		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 Florence Nursing Home

# 0041657

Report Period Beginning:

01/01/10

Ending: 12/31/10

**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 \_\_\_\_\_

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Florence Nursing Home

# 0041657

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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	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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	CHASE	X	Mortgage	\$14,267.81	12/14/04	\$ 1,750,000	\$	12/14/14	7.3200	\$ 76,957	1								
2	BANK LEUMI	X	Mortgage	\$18,273.00	09/03/10	2,500,000	2,482,405	09/03/20	5.0000	37,225	2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>			\$32,540.81		\$ 4,250,000	\$ 2,482,405			\$ 114,182	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income									(1,155)	10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			(1,155)	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 4,250,000	\$ 2,482,405			\$ 113,027	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

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

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

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

**B. Real Estate Taxes**

		<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>38,227</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>28,543</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(9,684)</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>29,114</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>19,430</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<b>14,084</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2006	<b>16,279</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009 \$
	2007	<b>35,959</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	2008	<b>37,477</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$
	2009	<b>28,543</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>28543 x 1.02</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.**

## 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Florence Nursing Home COUNTY Mchenry

FACILITY IDPH LICENSE NUMBER 0041657

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 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.	<u>11-36-327-024</u>	<u></u>	\$ <u>7,421.00</u>	\$ <u>7,421.00</u>
2.	<u>11-36-327-023</u>	<u></u>	\$ <u>13,415.00</u>	\$ <u>13,415.00</u>
3.	<u>11-36-327-022</u>	<u></u>	\$ <u>7,707.00</u>	\$ <u>7,707.00</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>28,543.00</u>	\$ <u>28,543.00</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 Florence Nursing Home

# 0041657

Report Period Beginning:

01/01/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 12,500 B. General Construction Type: Exterior Frame Number of Stories \_\_\_\_\_

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: 157,981 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 49,218 4. Dates Incurred: 1996,2004,2010

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>			\$ <u>400,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			\$ <b>400,000</b>	<b>3</b>

Facility Name &amp; ID Number Florence Nursing Home

# 0041657

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	52	1996		\$ 650,000	\$ 25,641	39	\$ 16,667	\$ (8,974)	\$ 356,625	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Remodeling-2002:		2002	147,500	3,778	39	3,782	4	33,695	9
10	Wall to Wall Carpeting, Wall Paper- Entire Building									10
11	Hot Water Heater and Holding Tank, New Beauty Shop.									11
12	Rebuilt West Nursing Station, New Elevator Roofing									12
13	New Kitchen and Flooring, New monitoring Satelite for Fire Alarm									13
14	New Lighting - West		2004	12,000	709	15	800	91	6,089	14
15	Remodeling 2005:		2005	260,825	6,677	39	6,688	11	40,212	15
16	8 New Doors, construction of 4 Bathrooms									16
17	New Hydrolic Pump for Elevator, New Ceiling- East Lobby									17
18	Flooring- Dining Area, New Emergency Lighting									18
19	Fire Proof Bldg, Walkways from Exit Floor									19
20	Paving		2009	17,500	1,663	15	1,167	(496)	1,750	20
21	Remodeling 2010:		2010							21
22	Renovation Corridor, Resident Rooms, Dining Room									22
23	First Floor Day Room, Therapy Rooms, Therapy Office, and									23
24	Therapy Bathrooms									24
25	New Flooring			107,773	107,773	27.5	3,919	(103,854)	3,919	25
26	Installation of New Wallcovering, Handrails ,Bumper Guards									26
27	and celing Tiles			45,976	45,976	27.5	1,672	(44,304)	1,672	27
28	Installation of Window Treatments			11,944	11,944	27.5	434	(11,510)	434	28
29	Painting All Walls and Celings			64,576	64,576	27.5	2,348	(62,228)	2,348	29
30	New Lighting and Signage			8,036	8,036	27.5	292	(7,744)	292	30
31	Installation of new wardrobes			7,450	7,450	27.5	271	(7,179)	271	31
32	Custom Laminate Millwork Nightstand with Polished grnite top.									32
33	Bookcase and Overbead Lamp			39,700	39,700	27.5	1,444	(38,256)	1,444	33
34	Renovation of Bathroom			5,539	5,539	27.5	201	(5,338)	201	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



Facility Name & ID Number Florence Nursing Home

# 0041657

Report Period Beginning:

01/01/10

Ending:

12/31/10

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)	\$	\$		\$	\$	\$	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	30,107	30,107	3,011	(27,096)	10	3,011	72
73	Fully Depreciated Assets	200,000					200,000	73
74								74
75	TOTALS	\$ 230,107	\$ 30,107	\$ 3,011	\$ (27,096)		\$ 203,011	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)	\$ 2,008,926	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 359,569	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,696	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (316,873)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 651,963	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ _____			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	<b>TOTAL</b>		\$ _____	\$ _____	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?</p> <p><input type="checkbox"/> YES      <input checked="" 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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.

Facility Name & ID Number Florence Nursing Home

# 0041657

Report Period Beginning: 01/01/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 56,731	\$ 755,557	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	709,835	709,835	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,264	48,264	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from others</u>	302,134	555,846	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,116,964	\$ 2,069,502	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		650,000	14
15	Leasehold Improvements, at Historical Cost	733,819	733,819	15
16	Equipment, at Historical Cost	30,107	230,107	16
17	Accumulated Depreciation (book methods)	(403,508)	(987,055)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		157,981	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(91,558)	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>	\$ 360,418	\$ 1,093,294	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,477,382	\$ 3,162,796	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 94,143	\$ 94,143	26
27	Officer's Accounts Payable	256,101	256,101	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,556	37,556	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,114	1,114	31
32	Accrued Real Estate Taxes(Sch.IX-B)		29,114	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to LLC</u>	10,278		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 399,192	\$ 418,028	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		2,482,405	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>	\$	\$ 2,482,405	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 399,192	\$ 2,900,433	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,078,190	\$ 262,363	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,477,382	\$ 3,162,796	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,066,093</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>1,066,093</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>887,097</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>(875,000)</b>	<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>12,097</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,078,190</b>	<b>24</b> *

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

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**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	\$ 3,316,577	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,316,577	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***	1,155	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,155	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>	\$ 3,317,732	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	517,354	31
32	Health Care	811,913	32
33	General Administration	522,970	33
<b>B. Capital Expense</b>			
34	Ownership	549,928	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	28,470	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,430,635	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	887,097	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 887,097	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash Basis 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.



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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	1,720	1,800	\$ 57,963	\$ 32.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,504	5,619	126,683	22.55	3
4	Licensed Practical Nurses	5,860	6,018	130,603	21.70	4
5	CNAs & Orderlies	38,030	39,511	408,728	10.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,038	2,139	29,830	13.95	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,831	1,835	24,406	13.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,945	11,312	105,340	9.31	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,104	41,144	19.56	17
18	Housekeepers	2,822	3,034	24,941	8.22	18
19	Laundry	1,563	1,588	18,482	11.64	19
20	Administrator	2,080	2,240	69,160	30.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,973	2,104	25,223	11.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	76,446	79,304	\$ 1,062,503 *	\$ 13.40	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	94	4,700	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	77	4,251	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	60	2,890	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	231	\$ 11,841		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





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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,500 Line 10
- (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. \$ 28,470  
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? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,000 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 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? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No  
**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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (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.