

		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 THIS INFORMATION IS MANDATORY FOR LONG-TERM CARE FACILITIES THAT IS NECESSARY TO ACCOMPLISH THE PURPOSE AS OUTLINED IN 210 ILCS 4. ANY INFORMATION ON OR BEFORE THE RESULT IN CESSATION OF PROGRAM HAS BEEN APPROVED BY THE FORM:

<p>I. IDPH License ID Number: <u>0040626</u></p> <p>Facility Name: <u>Peachtree Estates</u></p> <p>Address: <u>1370 State Route 127 South</u> <u>Jonesboro</u> <u>62952</u> <small>Number City Zip Code</small></p> <p>County: <u>Union</u></p> <p>Telephone Number: <u>618-833-5344</u> Fax # <u>618-833-8217</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/21/95</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input 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>In the event there are further questions about this report, please contact: Name: <u>Gary Griffith</u> Telephone Number: <u>618-833-5344</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input 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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p style="text-align: center;">I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2009</u> to <u>June 30, 2010</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p style="text-align: center;">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%; border: none;">Officer or Administrator of Provider</td> <td style="width: 10%; border: none;">(Signed) _____</td> <td style="width: 10%; border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;">(Type or Print Name)</td> <td colspan="2" style="border: none;"><u>Gary Griffith</u></td> </tr> <tr> <td style="border: none;">(Title)</td> <td colspan="2" style="border: none;"><u>Administrator</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;">(Print Name and Title)</td> <td colspan="2" style="border: none;"><u>Joseph B. Beussink</u> <u>CPA</u></td> </tr> <tr> <td style="border: none;">(Firm Name & Address)</td> <td colspan="2" style="border: none;"><u>Beussink & Hickam PC</u> <u>PO Box 556, Anna, IL 62906</u></td> </tr> <tr> <td style="border: none;">(Telephone)</td> <td style="border: none;"><u>618-833-2721</u></td> <td style="border: none;">Fax # (<u>618-833-7077</u>)</td> </tr> </table> <p style="font-size: small;">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name)	<u>Gary Griffith</u>		(Title)	<u>Administrator</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title)	<u>Joseph B. Beussink</u> <u>CPA</u>		(Firm Name & Address)	<u>Beussink & Hickam PC</u> <u>PO Box 556, Anna, IL 62906</u>		(Telephone)	<u>618-833-2721</u>	Fax # (<u>618-833-7077</u>)
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Facility Name & ID Number Peachtree Estates

0040626 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,727			5,364	13
14	TOTALS	5,727			5,364	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.85%

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

120 (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 04/21/95

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/21/95 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number

Peachtree Estates

#

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	52,386	35,715	3,700	91,801		91,801		91,801		1
2	Food Purchase										2
3	Housekeeping	24,257	1,955		26,212		26,212		26,212		3
4	Laundry	12,128	1,051		13,179		13,179		13,179		4
5	Heat and Other Utilities			12,549	12,549		12,549		12,549		5
6	Maintenance		10,463	14,202	24,665		24,665		24,665		6
7	Other (specify):*										7
8	TOTAL General Services	88,771	49,184	30,451	168,406		168,406		168,406		8
	B. Health Care and Programs										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	206,188	8,815	43,562	258,565		258,565		258,565		10
10a	Therapy			4,585	4,585		4,585		4,585		10a
11	Activities		523	736	1,259		1,259		1,259		11
12	Social Services			638	638		638		638		12
13	CNA Training	3,099		2,403	5,502		5,502		5,502		13
14	Program Transportation			6,484	6,484		6,484		6,484		14
15	Other (specify):*			6,335	6,335		6,335		6,335		15
16	TOTAL Health Care and Programs	209,287	9,338	66,543	285,168		285,168		285,168		16
	C. General Administration										
17	Administrative	46,961	665	23,808	71,434		71,434	(1,000)	70,434		17
18	Directors Fees										18
19	Professional Services			25,917	25,917		25,917		25,917		19
20	Dues, Fees, Subscriptions & Promotions			12,417	12,417		12,417		12,417		20
21	Clerical & General Office Expenses	3,155	2,733		5,888		5,888		5,888		21
22	Employee Benefits & Payroll Taxes			43,981	43,981		43,981		43,981		22
23	Inservice Training & Education			212	212		212		212		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,445	1,445		1,445	(184)	1,261		25
26	Insurance-Prop.Liab.Malpractice			5,968	5,968		5,968		5,968		26
27	Other (specify):*			1,578	1,578		1,578		1,578		27
28	TOTAL General Administration	50,116	3,398	115,326	168,840		168,840	(1,184)	167,656		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	348,174	61,920	212,320	622,414		622,414	(1,184)	621,230		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 & ID Number

Peachtree Estates

#0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,321	18,321		18,321	(1,654)	16,667			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,291	22,291		22,291		22,291			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			2,642	2,642		2,642		2,642			36
37	TOTAL Ownership			43,254	43,254		43,254	(1,654)	41,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,914	38,914		38,914		38,914			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,914	38,914		38,914		38,914			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	348,174	61,920	294,488	704,582		704,582	(2,838)	701,744			45

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

Facility Name & ID Number

Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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)	184	3, 25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>commuting depreciation</u>	1,654	4, 30		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,838		\$	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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 1,838		37

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

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

(See instructions.)

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

BHF USE ONLY

48		49		50		51		52
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Peachtree Estates

ID# 0040626

Report Period Beginning: July 1, 2009

Ending: June 30, 2010

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Related party management fee	\$ (1,000)	17	1
2	Commuting vehicle expense	(184)	25	2
3	Commuting portion of vehicle depreciation	(1,654)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,838)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Num Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending: June 30, 2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Progr	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,000)	0	0	0	0	0	0	0	0	0	0	(1,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expense	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(184)	0	0	0	0	0	0	0	0	0	0	(184)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administratio	(1,184)	0	0	0	0	0	0	0	0	0	0	(1,184)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,184)	0	0	0	0	0	0	0	0	0	0	(1,184)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	v	Management Fee	\$ 18,000	RAVE Inc.	100.00%	\$ 17,000	\$	(1,000)	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		\$ 18,000			\$ 17,000	\$ *	(1,000)	14

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

Facility Name & ID Number

Peachtree Estates

#

0040626

Report Period Beginning

July 1, 2009

Ending:

June 30, 2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number

Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending:

une 30, 2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES NO

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

 () _____
 () _____

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

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

Facility Name & ID Number

Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	IDFA Pooled Loan		x	Building & equipment	\$5,076.00	03/01/*8	\$	297,655	07/01/14	0.0495	\$ 17,208	1								
2	AJ National Bank		x	vehicle loans		various		16,530			1,683	2								
3												3								
4												4								
5												5								
Working Capital																				
6	AJ National Bank					various		65,000			1,923	6								
7	Credit cards and accounts					various					1,477	7								
8												8								
9	TOTAL Facility Related				\$5,076.00		\$	379,185			\$ 22,291	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$				\$	14								
15	TOTALS (line 9+line14)						\$	379,185			\$ 22,291	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																		
1. Real Estate Tax accrual used on 2009 report.		\$	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	3															
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7															
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2005</td> <td>8</td> </tr> <tr> <td></td> <td>2006</td> <td>9</td> </tr> <tr> <td></td> <td>2007</td> <td>10</td> </tr> <tr> <td></td> <td>2008</td> <td>11</td> </tr> <tr> <td></td> <td>2009</td> <td>12</td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2005	8		2006	9		2007	10		2008	11		2009	12
Real Estate Tax Bill for Calendar Year:	2005	8																
	2006	9																
	2007	10																
	2008	11																
	2009	12																
		FOR BHF USE ONLY																
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	13														
	14	PLUS APPEAL COST FROM LINE 5	\$	14														
	15	LESS REFUND FROM LINE 6	\$	15														
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16														

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Peachtree Estates COUNTY Union

FACILITY IDPH LICENSE NUMBER 0040626

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the po cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of tl home property which is vacant, rented to other organizations, or used for purposes other than long term care mus entered in Column D. Do not include cost for any period other than calendar year 2009.

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

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 di used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing hor (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 20 tax bill which is normally paid during 2010.

PLEASE NOTE: Payment information from the Internet not considered acceptable tax bill
documentation *copies* second
installment

Facility Name & ID Number Peachtree Estates # 0040626 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,560 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>facility</u>	<u>60,000</u>	<u>1994</u>	<u>\$ 43,586</u>	1
2					2
3	TOTALS	60,000		\$ 43,586	3

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	
Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1995	1995	\$ 408,923	\$ 8,178	50	\$ 8,178		\$ 126,765
5		1995	1995	2,484	166	15	166		2,403
6		1996	1996	1,240		10			1,240
7									
8									
Improvement Type**									
9	carpet and tile		1996	5,540	370	15	370		4,988
10	tile base & rooms		1998	2,512		15			2,512
11	driveway		2006	2,594		15			2,594
12	driveway		1999	976	65	15	65		710
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

See Page 12A, Line 70 for total

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

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	\$ 69,039	\$ 1,540	\$ 1,540	\$	7	\$ 61,398	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 69,039	\$ 1,540	\$ 1,540	\$		\$ 61,398	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	2006 Pontiac Montana	2008	\$ 17,500	\$ 4,667	\$ 4,667	\$	3	\$ 11,668	76
77	Administration	2005 Honda	2008	\$ 12,505	\$ 3,335	\$ 3,335	\$	3	\$ 6,670	77
78										78
79										79
80	TOTALS			\$ 30,005	\$ 8,002	\$ 8,002	\$		\$ 18,338	80

E. Summary of Care-Related Assets

	1	2	
		Reference	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)	\$ 566,899
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,321
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,321
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 220,948

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.

Facility Name & ID Number

Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending: June 30, 2010

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? YES NO

If NO, see instructions.

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2011	\$ _____
13.	_____ /2012	\$ _____
14.	_____ /2013	\$ _____

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

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

Facility Name & ID Number

Peachtree Estates

#

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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 style="text-align: right;"> <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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</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	1		2		3		4	
		Drop-outs	Completed	Drop-outs	Completed	Contract	Total	Drop-outs	Completed
1	Community College Tuition	\$ 175	\$ 1,750					\$	1,925
2	Books and Supplies	43	435						478
3	Classroom Wages (a)	330	3,300						3,630
4	Clinical Wages (b)		6,600						6,600
5	In-House Trainer Wages (c)	281	2,818						3,099
6	Transportation								
7	Contractual Payments								
8	CNA Competency Tests								
9	TOTALS	\$ 829	\$ 14,903	\$	\$			\$	15,732
10	SUM OF line 9, col. 1 and 2 (e)	\$ 15,732							

- (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.

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	

- (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.

Facility Name & ID Number

Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number

Peachtree Estates

#

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

June 30, 2010

(last day of reporting year)

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

	1	2	
	Operating	After	
		Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,598	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	378,843	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	7,902	6
7	Other Prepaid Expenses	1,459	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 394,802	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	43,586	13
14	Buildings, at Historical Cost	424,269	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	99,044	16
17	Accumulated Depreciation (book methods)	(220,948)	17
18	Deferred Charges	9,366	18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 355,317	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 750,119	25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 230,482	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	65,000	29
30	Accrued Salaries Payable	13,883	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,593	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36			36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 311,958	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,530	39
40	Mortgage Payable		40
41	Bonds Payable	297,654	41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 314,184	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 626,142	46
47	TOTAL EQUITY(page 18, line 24)	\$ 123,977	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 750,119	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 134,879	1
2	Restatements (describe):		2
3	Audit adjustments	(10,231)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 124,648	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(671)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (671)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 123,977	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number

Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 703,911	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 703,911	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 703,911	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	168,406	31
32	Health Care	285,168	32
33	General Administration	168,840	33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers	43,254	35
36	Provider Participation Fee	38,914	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 704,582	40
41	Income before Income Taxes (line 30 minus line 40)**	(671)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (671)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses				3	
4	Licensed Practical Nurses				4	
5	CNAs & Orderlies				5	
6	CNA Trainees				6	
7	Licensed Therapist				7	
8	Rehab/Therapy Aides				8	
9	Activity Director				9	
10	Activity Assistants				10	
11	Social Service Workers				11	
12	Dietician				12	
13	Food Service Supervisor				13	
14	Head Cook	3,854	4,189	52,386	12.51	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,519	2,738	24,257	8.86	18
19	Laundry	1,260	1,370	12,128	8.85	19
20	Administrator	765	832	15,995	19.22	20
21	Assistant Administrator	938	1,020	17,250	16.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	290	315	3,155	10.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	850	924	13,716	14.84	29
30	Habilitation Aides (DD Homes)	21,412	23,274	206,188	8.86	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>CAN Trainer</u>	155	155	3,099	19.99	33
34	TOTAL (lines 1 - 33)	32,043	34,817	\$ 348,174 *	\$ 10.00	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	48	\$ 3,109	1, 3	35
36	Medical Director	12	1,800	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	6	650	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	24	1,680	10a, 3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	39	2,905	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	129	\$ 10,144		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	1,680	33,544	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,680	\$ 33,544		53

Facility Name & ID Number

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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		
Gary Griffith	Administrator		\$ 15,955	Workers' Compensation Insurance	\$ 14,239	IDPH License Fee	\$		
Joan Patton	Asst. Admin.		15,959	Unemployment Compensation Insurance	7,791	Advertising: Employee Recruitment	4,698		
Various	RSD		15,047	FICA Taxes	21,478	Health Care Worker Background Check			
				Employee Health Insurance		(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	720		
				Illinois Municipal Retirement Fund (IMRF)*		IARF Fees	4,698		
						Other License and Fees	2,301		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 46,961						
B. Administrative - Other						Less: Public Relations Expense	()		
Description			Amount			Non-allowable advertising	()		
			\$			Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 43,508	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,417
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Aschemann Keller	Legal		\$ 1,262			\$	Out-of-State Travel	\$	
Stratton, Giganti Et Al	Legal		15,181						
Beussink & Hickam	CPA		6,864				In-State Travel		
MPRO	Legal		2,610						
							Seminar Expense		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 25,917	TOTAL		\$	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)	\$	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number

Peachtree Estates

0040626

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount IARF \$7,249
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,782 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. \$ 38,914
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 I no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 0 Indicate the amount \$ 0
- (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? 95
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? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm? will be
Firm Name: Beussink & Hickam PC
- (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? yes
Attach invoices and a summary of services for all architect and appraisal fees.