

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0038497</u></p> <p>Facility Name: <u>The Tish Hewitt House</u></p> <p>Address: <u>5102 52nd Avenue</u> <u>Moline</u> <u>61265</u> <small>Number City Zip Code</small></p> <p>County: <u>Rock Island</u></p> <p>Telephone Number: <u>309 786-6474</u> Fax # <u>309 786-9861</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/12/92</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</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>503c</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>David Daughtery</u> Telephone Number: <u>309 786-6474</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>503c</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/09</u> to <u>6/30/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Stacey Cary</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Associate Executive Director</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) () () Fax # () ()</td> </tr> </table> <p align="right">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>Stacey Cary</u>		(Title) <u>Associate Executive Director</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () () Fax # () ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
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Paid Preparer	(Signed) _____ (Date) _____																																						
	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) () () Fax # () ()																																						

Facility Name & ID Number The Tish Hewitt House

0038497 Report Period Beginning: 7/1/09 Ending: 6/30/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 8

	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	<u>2,920</u>	Intermediate (ICF)	<u>8</u>	<u>2,920</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>2920</u>	TOTALS	<u>8</u>	<u>2,920</u>	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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>2,902</u>			<u>2,902</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,902</u>			<u>2,902</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.38%

D. How many bed-hold days during this year were paid by the Department? 18 (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 12/12/92

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/12/92 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 No

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number The Tish Hewitt House # 0038497 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		1,734	954	2,688		2,688		2,688		1
2	Food Purchase		18,368		18,368	(2,150)	16,218	6	16,224		2
3	Housekeeping		4,053	692	4,745		4,745	414	5,159		3
4	Laundry										4
5	Heat and Other Utilities			6,487	6,487		6,487	145	6,632		5
6	Maintenance		9,427	1,324	10,751		10,751	447	11,198		6
7	Other (specify):*										7
8	TOTAL General Services		33,582	9,457	43,039	(2,150)	40,889	1,012	41,901		8
	B. Health Care and Programs										
9	Medical Director			1,375	1,375		1,375		1,375		9
10	Nursing and Medical Records	165,054	5,302		170,356		170,356	95	170,451		10
10a	Therapy										10a
11	Activities		466		466		466		466		11
12	Social Services	7,636			7,636		7,636		7,636		12
13	CNA Training		16		16		16		16		13
14	Program Transportation		4,063		4,063		4,063		4,063		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	172,690	9,847	1,375	183,912		183,912	95	184,007		16
	C. General Administration										
17	Administrative	54,784			54,784		54,784	18,066	72,850		17
18	Directors Fees										18
19	Professional Services							1,836	1,836		19
20	Dues, Fees, Subscriptions & Promotions			1,080	1,080		1,080	840	1,920		20
21	Clerical & General Office Expenses	2,896	506	2,198	5,600		5,600	704	6,304		21
22	Employee Benefits & Payroll Taxes			44,863	44,863	2,150	47,013	4,833	51,846		22
23	Inservice Training & Education							9	9		23
24	Travel and Seminar			144	144		144	62	206		24
25	Other Admin. Staff Transportation		1,047		1,047		1,047	147	1,194		25
26	Insurance-Prop.Liab.Malpractice			3,181	3,181		3,181	258	3,439		26
27	Other (specify):*										27
28	TOTAL General Administration	57,680	1,553	51,466	110,699	2,150	112,849	26,755	139,604		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	230,370	44,982	62,298	337,650		337,650	27,862	365,512		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

The Tish Hewitt House

#0038497

Report Period Beginning:

7/1/09

Ending:

6/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			13,873	13,873		13,873	1,064	14,937			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			13,873	13,873		13,873	1,064	14,937			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			20,667	20,667		20,667		20,667			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			20,667	20,667		20,667		20,667			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	230,370	44,982	96,838	372,190		372,190	28,926	401,116			45

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

The Tish Hewitt House

ID# 0038497

Report Period Beginning: 7/1/09

Ending: 6/30/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Tish Hewitt House# 0038497

Report Period Beginning:

7/1/09

Ending:

6/30/10

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	6	0	0	0	0	0	0	0	0	0	6	2
3	Housekeeping	0	414	0	0	0	0	0	0	0	0	0	414	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	145	0	0	0	0	0	0	0	0	0	145	5
6	Maintenance	0	447	0	0	0	0	0	0	0	0	0	447	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,012	0	0	0	0	0	0	0	0	0	1,012	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	95	0	0	0	0	0	0	0	0	0	95	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	95	0	0	0	0	0	0	0	0	0	95	16
	C. General Administration													
17	Administrative	0	18,066	0	0	0	0	0	0	0	0	0	18,066	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,836	0	0	0	0	0	0	0	0	0	1,836	19
20	Fees, Subscriptions & Promotions	0	840	0	0	0	0	0	0	0	0	0	840	20
21	Clerical & General Office Expenses	0	704	0	0	0	0	0	0	0	0	0	704	21
22	Employee Benefits & Payroll Taxes	0	4,833	0	0	0	0	0	0	0	0	0	4,833	22
23	Inservice Training & Education	0	9	0	0	0	0	0	0	0	0	0	9	23
24	Travel and Seminar	0	0	62	0	0	0	0	0	0	0	0	62	24
25	Other Admin. Staff Transportation	0	0	147	0	0	0	0	0	0	0	0	147	25
26	Insurance-Prop.Liab.Malpractice	0	0	258	0	0	0	0	0	0	0	0	258	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	26,288	467	0	0	0	0	0	0	0	0	26,755	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	27,395	467	0	0	0	0	0	0	0	0	27,862	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Tish Hewitt House# 0038497

Report Period Beginning:

7/1/09

Ending:

6/30/10

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)	
	D. Ownership													
30	Depreciation	0	0	1,064	0	0	0	0	0	0	0	0	1,064	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	1,064	0	0	0	0	0	0	0	0	1,064	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	27,395	1,531	0	0	0	0	0	0	0	0	28,926	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
None						

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	2 Food and Beverage	\$	ARCRIC	100.00%	\$ 6	\$	6	1
2	V	3 Housekeeping		ARCRIC	100.00%	414		414	2
3	V	5 Utilities		ARCRIC	100.00%	145		145	3
4	V	6 Maintenance		ARCRIC	100.00%	447		447	4
5	V	19 Account/Consult		ARCRIC	100.00%	1,390		1,390	5
6	V	19 Legal Fees		ARCRIC	100.00%	446		446	6
7	V	17 Administration Salaries		ARCRIC	100.00%	18,066		18,066	7
8	V	20 Sub/Promotion/Printing		ARCRIC	100.00%	840		840	8
9	V	21 Office Supplies		ARCRIC	100.00%	584		584	9
10	V	21 Telephone		ARCRIC	100.00%	120		120	10
11	V	22 Employee Benefits		ARCRIC	100.00%	4,833		4,833	11
12	V	10 Medical/Hygiene Supplies		ARCRIC	100.00%	95		95	12
13	V	23 Staff Training		ARCRIC	100.00%	9		9	13
14	Total		\$			\$ 27,395	\$ *	27,395	14

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

Facility Name & ID Number The Tish Hewitt House

0038497

Report Period Beginning: 7/1/09

Ending: 6/30/10

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	24 Travel Seminar	\$	ARCRIC	100.00%	\$ 62	\$	62	15
16	V	25 Other Administration, Staff Transportation		ARCRIC	100.00%	147		147	16
17	V	26 Insurance/Prof/Liability		ARCRIC	100.00%	258		258	17
18	V	30 Depreciation		ARCRIC	100.00%	1,064		1,064	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 1,531	\$ *	1,531	39

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

Facility Name & ID Number

The Tish Hewitt House

#

0038497

Report Period Beginning:

7/1/09

Ending:

6/30/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	None								\$	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 The Tish Hewitt House

0038497

Report Period Beginning:

7/1/09

Ending: 6/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Association for Retarded Citizens
 Street Address 4016 9th Street
 City / State / Zip Code Rock Island IL 61201
 Phone Number (309 786-6474
 Fax Number (309 786-9861

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	2	Food and Beverage	The percent of budgeted	20 programs	\$ 196	\$	36,368	\$ 6	1
2	3	Housekeeping	Administrative costs are	20 programs	13,373		36,368	414	2
3	5	Utilities	to be allocated based on	20 programs	4,681		36,368	145	3
4	6	Maintenance	percentage of salary	20 programs	14,439		36,368	447	4
5	19	Accountant/Consultant		20 programs	44,932		36,368	1,390	5
6	19	Legal Fees		20 programs	14,401		36,368	446	6
7	17	Administrative Salaries		20 programs	583,788		36,368	18,066	7
8	20	Sub/Promotion/Printing		20 programs	27,160		36,368	840	8
9	21	Office Expense		20 programs	18,868		36,368	584	9
10	21	Telephone		20 programs	3,886		36,368	120	10
11	22	Employee Benefits		20 programs	156,172		36,368	4,833	11
12	10	Medical/Hygiene Supplies		20 programs	3,063		36,368	95	12
13	23	Staff Training		20 programs	278		36,368	9	13
14	24	Travel Seminar		20 programs	2,006		36,368	62	14
15	25	Other Administrative, Staff Transportation		20 programs	4,764		36,368	147	15
16	26	Insurance/Prof/Liability		20 programs	8,345		36,368	258	16
17	30	Depreciation		20 programs	34,397		36,368	1,064	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 934,749	\$		\$ 28,926	25

Facility Name & ID Number

The Tish Hewitt House

0038497

Report Period Beginning:

7/1/09

Ending:

6/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	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.)

Facility Name & ID Number The Tish Hewitt House

0038497

Report Period Beginning:

7/1/09

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6/30/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Tish Hewitt House COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0038497

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number The Tish Hewitt House

0038497

Report Period Beginning:

7/1/09

Ending:

6/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,307 B. General Construction Type: Exterior Vinyl Siding 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).

None

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: None 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>DD Facility</u>	<u>26,260</u>	<u>1972</u>	<u>\$ 22,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	26,260		\$ 22,000	3

Facility Name & ID Number Tish Hewitt House

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	8	1992	1992	\$ 283,439	\$ 8,998	31.5	\$ 8,998		\$ 157,465
5									
6									
7									
8									
Improvement Type**									
9	Water Temp valve		1994	1,885	60	31.5	60		929
10	Final General Construction Billing of Building		1995	1,051	33	31.5	33		692
11	Mixing Valve Backflow		1998	745	24	31.5	24		299
12	Vinyl Flooring		1998	809	26	31.5	26		324
13	Concrete Patio/Carpet/Plumbing Backflow		1999	5,328	169	31.5	169		1,861
14	Automatic Doors		2000	2,253	71	31.5	71		674
15	Tile Bathroom		2001	997	32	31.5	32		272
16	Vinyl Flooring/Kitchen and Dining Room		2002	3,153	100	31.5	100		750
17	Install Handrails		2005	1,239	39	31.5	39		215
18	Install Fence and 2 Gates		2005	2,001	64	31.5	64		352
19	Materials and Build Gazebo		2006	8,747	278	31.5	278		1,251
20	Concrete Sidewalk		2007	1,550	49	31.5	49		172
21	New Vinyl Flooring		2007	1,630	52	31.5	52		182
22	New Window Blinds		2008	3,924	125	31.5	125		312
23	Relocate/Replace Sprinkler in Front Entry Way		2009	846	27	31.5	27		40
24	Install Tile Flooring Men's suites/bathrooms		2009	2,798	89	31.5	89		133
25	Install Transfer Switch for Generator		2009	1,308	42	31.5	42		63
26	Roof/Siding		2010	15,525	247	31.5	247		247
27	Repair Roof/Siding due to Hail Damage		2010	1,000	16	31.5	16		16
28									
29									
30									
31									
32									
33									
34									
35									
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 The Tish Hewitt House

0038497

Report Period Beginning:

7/1/09

Ending:

6/30/10

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)	\$ 340,228	\$ 10,541		\$ 10,541	\$	\$ 166,249	70

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

Facility Name & ID Number The Tish Hewitt House

0038497

Report Period Beginning:

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Ending:

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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	\$ 35,661	\$ 1,114	\$ 1,114	\$	10	\$ 32,186	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 35,661	\$ 1,114	\$ 1,114	\$		\$ 32,186	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 Care	2005 Chevy Uplander	2005	\$ 16,140	\$ 3,282	\$ 3,282	\$		\$ 16,410	76
77										77
78										78
79										79
80	TOTALS			\$ 16,140	\$ 3,282	\$ 3,282	\$		\$ 16,410	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)	\$ 414,029	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,937	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,937	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 214,845	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	TOTAL				\$ _____			7

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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><u>No CNA's were hired during this period</u></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	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 The Tish Hewitt House# 0038497Report Period Beginning: 7/1/09

Ending:

6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

6/30/10

(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	\$ 118,460	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	39,088		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	64		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 157,612	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,000		13
14	Buildings, at Historical Cost	340,228		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,801		16
17	Accumulated Depreciation (book methods)	(214,845)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 199,184	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 356,796	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,867	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,886		30
31	Accrued Taxes Payable (excluding real estate taxes)			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)	\$ 56,753	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 56,753	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 300,043	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 356,796	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 295,367	1
2	Restatements (describe):		2
3	Reclassification of Fixed Assets	7,364	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 302,731	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,688)	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)	\$ (2,688)	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)	\$ 300,043	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 357,064	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 357,064	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	62	9
10	Other Government Grants	776	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	520	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	8,424	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,782	23
D. Non-Operating Revenue			
24	Contributions	2,328	24
25	Interest and Other Investment Income***	328	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,656	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)	\$ 369,502	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	43,039	31
32	Health Care	183,912	32
33	General Administration	110,699	33
B. Capital Expense			
34	Ownership	13,873	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	20,667	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 372,190	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,688)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,688)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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
2	Assistant Director of Nursing				2
3	Registered Nurses	174	4,500	24.06	3
4	Licensed Practical Nurses	342	5,843	15.88	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				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator	466	15,584	31.11	20
21	Assistant Administrator	1,946	39,200	18.73	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	196	2,896	13.73	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	483	7,636	14.68	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	12,555	154,711	11.46	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	16,162	230,370 *	\$ 13.25	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	24	\$ 954	35
36	Medical Director	annual	1,375	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	24	\$ 2,329	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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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	
Jane O'Melia	Administrator		\$ 15,584	Workers' Compensation Insurance	\$ 7,561	IDPH License Fee	\$ 250	
Karen Steen	Supervisor		39,200	Unemployment Compensation Insurance	451	Advertising: Employee Recruitment	432	
				FICA Taxes	16,745	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	8,130	<u>Patient Background Checks</u>		
				Employee Meals	2,150	Subscription	34	
				Illinois Municipal Retirement Fund (IMRF)*		Staff Award and Recognition	454	
				<u>Pension Expense Employer Paid</u>	11,617	Arc of IL and US Dues	658	
				<u>Disability Insurance</u>	40	Direct Deposit Fees	93	
				<u>Group Term Insurance</u>	315			
				<u>Admin Fringe Benefits from schedule VIII 11 c9</u>	4,833	Less: Public Relations Expense	()	
				<u>Immunization Costs</u>	4	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 54,784	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,920
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
							Out-of-State Travel	
							In-State Travel	
							206	
							Seminar Expense	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 206	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Tish Hewitt House# 0038497Report Period Beginning: 7/1/09Ending: 6/30/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (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. \$ 20,667
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? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,150 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? Yes 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? 100%
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?
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? Yes
Firm Name: McGladrey and Pullen, LLP
- (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.