

		FOR BHF USE					

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**2011  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2011)**

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

<p><b>I. IDPH License ID Number:</b> <u>0040105</u></p> <p><b>Facility Name:</b> <u>Autumn Lake</u></p> <p><b>Address:</b> <u>3515 Theodore Street</u> <u>Joliet</u> <u>60435</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Will</u></p> <p><b>Telephone Number:</b> <u>(815) 741-7606</u> <b>Fax #</b> <u>(815) 741-6740</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>7/27/93</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> <b>PROPRIETARY</b>  <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"/> <b>GOVERNMENTAL</b>  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>David Loncala, Finance Director</u> <b>Telephone Number:</b> <u>(815) 741-7606</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> <b>PROPRIETARY</b> <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"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/10</u> to <u>6/30/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>James A. Hogan</u> (Title) <u>President/Chief Executive Officer</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) (    )                      Fax # (    )</td> </tr> </table> <p align="right"><b>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</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>James A. Hogan</u> (Title) <u>President/Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (    )                      Fax # (    )
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> <b>PROPRIETARY</b> <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"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>James A. Hogan</u> (Title) <u>President/Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (    )                      Fax # (    )							

Facility Name & ID Number Autumn Lake

# 0040105 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	16	Intermediate/DD	16	5,840	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,002			5,002	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,002			5,002	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.65%

D. How many bed-hold days during this year were paid by the Department? 596 (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)  
\_\_\_\_\_

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 7/27/1993

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 7/27/1993 NO

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

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

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number Autumn Lake # 0040105 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	102,317	355	2,659	105,331		105,331	105,331			1
2	Food Purchase		30,284		30,284		30,284	30,284			2
3	Housekeeping	85,264	3,491		88,755		88,755	88,755			3
4	Laundry	85,264			85,264		85,264	85,264			4
5	Heat and Other Utilities			27,911	27,911		27,911	27,911			5
6	Maintenance	37,188	34,069	5,077	76,334		76,334	76,334			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>310,033</b>	<b>68,199</b>	<b>35,647</b>	<b>413,879</b>		<b>413,879</b>	<b>413,879</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	6,265			6,265		6,265	6,265			9
10	Nursing and Medical Records	307,397	1,034		308,431		308,431	308,431			10
10a	Therapy			2,161	2,161		2,161	2,161			10a
11	Activities										11
12	Social Services	5,660			5,660		5,660	5,660			12
13	CNA Training										13
14	Program Transportation			22,222	22,222		22,222	22,222			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>319,322</b>	<b>1,034</b>	<b>24,383</b>	<b>344,739</b>		<b>344,739</b>	<b>344,739</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	40,203			40,203		40,203	40,203			17
18	Directors Fees										18
19	Professional Services			4,769	4,769		4,769	4,769			19
20	Dues, Fees, Subscriptions & Promotions			6,141	6,141		6,141	6,141			20
21	Clerical & General Office Expenses	26,023		13,024	39,047		39,047	39,047			21
22	Employee Benefits & Payroll Taxes			178,818	178,818		178,818	178,818			22
23	Inservice Training & Education										23
24	Travel and Seminar			3,491	3,491		3,491	3,491			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			10,206	10,206		10,206	10,206			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>66,226</b>		<b>216,449</b>	<b>282,675</b>		<b>282,675</b>	<b>282,675</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>695,581</b>	<b>69,233</b>	<b>276,479</b>	<b>1,041,293</b>		<b>1,041,293</b>	<b>1,041,293</b>			<b>29</b>

\*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 Autumn Lake

#0040105

Report Period Beginning:

7/1/10

Ending:

6/30/11

## 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			52,160	52,160		52,160		52,160			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,509	18,509		18,509		18,509			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			36	36		36		36			34
35	Rent-Equipment & Vehicles			690	690		690		690			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			71,395	71,395		71,395		71,395			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			3,760	3,760		3,760		3,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,416	62,416		62,416		62,416			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			66,176	66,176		66,176		66,176			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	695,581	69,233	414,050	1,178,864		1,178,864		1,178,864			45

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



Autumn Lake

ID# 0040105

Report Period Beginning: 7/1/10

Ending: 6/30/11

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







**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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



Facility Name & ID Number Autumn Lake # 0040105 Report Period Beginning: 7/1/10 Ending: 6/30/11

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 Autumn Lake

# 0040105

Report Period Beginning:

7/1/10

Ending: 6/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Admin Staff Salaries	Direct Costs	21,565,631	\$ 826,394	\$ 826,394	1,049,129	\$ 40,203	1
2	19	Professional Services	Direct Costs	21,565,631	98,045		1,049,129	4,770	2
3	20	Dues, Fees, Subs, Promotion	Direct Costs	21,565,631	122,992		1,049,129	5,983	3
4	21	Clerical & General Office	Direct Costs	21,565,631	643,614	491,553	1,049,129	31,311	4
5	22	Employee Benefits & PR Taxes	Direct Costs	21,565,631	250,675		1,049,129	12,195	5
6	24	Travel & Seminar	Direct Costs	21,565,631	50,057		1,049,129	2,435	6
7	25	Other Admin Staff Trans	Direct Costs	21,565,631			1,049,129	0	7
8	26	Insurance	Direct Costs	21,565,631	65,009		1,049,129	3,163	8
9	27	Other	Direct Costs	21,565,631	4,737		1,049,129	230	9
10	6	Maintenance	Direct Costs	21,565,631	196,841	44,324	1,049,129	9,576	10
11	2	Food Purchase	Direct Costs	21,565,631	14,971		1,049,129	728	11
12	30	Depreciation	Direct Costs	21,565,631	214,669		1,049,129	10,443	12
13	35	Rent - Equipt / Vehicle	Direct Costs	21,565,631	12,576		1,049,129	612	13
14	34	Rent - Facility / Grounds	Direct Costs	21,565,631	607		1,049,129	30	14
15	32	Interest	Direct Costs	21,565,631	166,785		1,049,129	8,114	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,667,972	\$ 1,362,271		\$ 129,793	25

Facility Name & ID Number

Autumn Lake

# 0040105

Report Period Beginning:

7/1/10

Ending:

6/30/11

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	First Midwest Bank	X	Refinance Debt	\$1,500.00	9/26/08	\$ 249,775	\$ 241,163	9/26/12	6.0000	\$ 10,452	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>			\$1,500.00		\$ 249,775	\$ 241,163			\$ 10,452	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 249,775	\$ 241,163			\$ 10,452	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**

**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 2010 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 2011 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	2006	_____	8
	2007	_____	9
	2008	_____	10
	2009	_____	11
	2010	_____	12

  

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.**

# 2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Autumn Lake COUNTY Will

FACILITY IDPH LICENSE NUMBER 0040105

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 2010 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 2010.

	(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.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

**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 Autumn Lake

# 0040105

Report Period Beginning:

7/1/10

Ending:

6/30/11

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 7,103 B. General Construction Type: Exterior Aluminum Siding Frame Wood Number of Stories Ranch

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Residential</u>	<u>53,346</u>	<u>1993</u>	<u>\$ 117,400</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>53,346</b>		<b>\$ 117,400</b>	<b>3</b>



**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		1993	1993	\$ 216,268	\$ 9,539	25	\$ 9,539		\$ 147,342
5		1993	1993	199,232	7,951	25	7,951		133,509
6		1993	1993	224,411	10,202	25	10,202		143,171
7		1993	1993	233,819	10,915	25	10,915		149,002
8									
<b>Improvement Type**</b>									
9									
10									
11									
12									
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.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$ 873,730	\$ 38,607		\$ 38,607	\$	\$ 573,024	70

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

Facility Name & ID Number Autumn Lake

# 0040105

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 16,586	\$ 3,050	\$ 3,050	\$	5	\$ 13,756	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	27,123					27,123	73
74								74
75	TOTALS	\$ 43,709	\$ 3,050	\$ 3,050	\$		\$ 40,880	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,034,839	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,657	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,657	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)	\$ 613,904	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	2008 Chevy Uplander	\$ 16,279	\$ 3,256	\$ 8,140	86
87	2008 Chevy Uplander	33,324	3,332	8,331	87
88	2008 Chevy Uplander	16,279	3,256	8,140	88
89	2008 Chevy Uplander	16,279	3,256	8,140	89
90					90
91	TOTALS	\$ 82,161	\$ 13,100	\$ 32,750	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

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

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

\* 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 type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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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	L39,C3	visits			280			280	5
6	Dental Care	L39,C3	visits			2,750			2,750	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): <u>Podiatrist</u>	L39,C3				730			730	13
14	TOTAL			\$		\$ 3,760	\$		\$ 3,760	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 Autumn Lake

# 0040105

Report Period Beginning: 7/1/10

Ending: 6/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/11 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 18,262	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		2,335,616	3
4	Supply Inventory (priced at )		18,129	4
5	Short-Term Investments		291,406	5
6	Prepaid Insurance		220,631	6
7	Other Prepaid Expenses		5,195	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 2,889,239	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,859,895	12
13	Land		2,707,544	13
14	Buildings, at Historical Cost		25,069,975	14
15	Leasehold Improvements, at Historical Cost		107,286	15
16	Equipment, at Historical Cost		3,939,883	16
17	Accumulated Depreciation (book methods)		(13,676,528)	17
18	Deferred Charges		1,711,062	18
19	Organization & Pre-Operating Costs		81,553	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 21,800,670	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 24,689,909	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 289,800	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		906,234	29
30	Accrued Salaries Payable		849,903	30
31	Accrued Taxes Payable (excluding real estate taxes)		24,679	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		47,278	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 2,117,894	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		345,776	39
40	Mortgage Payable		1,060,843	40
41	Bonds Payable		12,953,049	41
42	Deferred Compensation		731,844	42
<b>Other Long-Term Liabilities(specify):</b>				
43	<b>Long-Term Debt, current portion</b>		(506,234)	43
44	<b>Unclaimed Property</b>		2,365	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 14,587,643	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 16,705,537	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$	\$ 7,984,372	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	\$ 24,689,909	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 7,407,165	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 7,407,165	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	577,207	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 577,207	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 7,984,372	<b>24</b> *

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



Facility Name &amp; ID Number Autumn Lake

# 0040105

Report Period Beginning: 7/1/10

Ending: 6/30/11

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,037,528	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,037,528	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,037,528	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	413,879	31
32	Health Care	344,739	32
33	General Administration	282,675	33
<b>B. Capital Expense</b>			
34	Ownership	71,395	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,760	35
36	Provider Participation Fee	62,416	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,178,864	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(141,336)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (141,336)	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 Autumn Lake

# 0040105

Report Period Beginning:

7/1/10

Ending:

6/30/11

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	616	18,491	30.02	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	332	5,660	17.05	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	8,760	102,317	11.68	15
16	Dishwashers				16
17	Maintenance Workers	2,755	37,188	13.50	17
18	Housekeepers	7,300	85,264	11.68	18
19	Laundry	7,300	85,264	11.68	19
20	Administrator	138	12,892	93.75	20
21	Assistant Administrator	432	27,311	63.21	21
22	Other Administrative	994	21,655	21.79	22
23	Office Manager				23
24	Clerical	500	4,368	8.74	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director	157	6,265	39.91	27
28	Qualified MR Prof. (QMRP)	3,081	47,786	15.51	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	20,644	241,120	11.68	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	53,009	695,581 *	\$ 13.12	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	\$ 2,659	L1,C3	35
36	Medical Director			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	0	L10a,C3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Psychologist, Psychiatrist	2,161	L10a,C3	47
48	Legal, Accounting, Misc	2,336	L19,C3	48
49	TOTAL (lines 35 - 48)	\$ 7,156		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

Facility Name & ID Number Autumn Lake

# 0040105

Report Period Beginning: 7/1/10

Ending: 6/30/11

**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		
Administrator	Exec Director	0	\$ 12,892	Workers' Compensation Insurance	\$ 26,376	IDPH License Fee	\$		
Asst Administrator	VP's of CSI	0	27,311	Unemployment Compensation Insurance	7,070	Advertising: Employee Recruitment	2,615		
				FICA Taxes	50,105	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	95,267	Patient Background Checks			
				Employee Meals		Subscriptions	115		
				Illinois Municipal Retirement Fund (IMRF)*		Postage & Shipping	1,277		
						Membership Dues	2,134		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 40,203						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount				Less: Public Relations Expense ( )		
			\$				Non-allowable advertising ( )		
							Yellow page advertising ( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
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	
Senesac & Lennon	Accounting/Audit		\$ 906			\$	Out-of-State Travel	\$	
Seyfarth Shaw & McKeown Law	Legal		1,218						
ADP	Payroll Processing		2,433				In-State Travel	1,443	
Don Moss & Assoc	Misc Consultant		212						
							Seminar Expense	2,048	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,769	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,491

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Autumn Lake

# 0040105

Report Period Beginning: 7/1/10

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A 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. \$ 62,416  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 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? N/A  
**g. Does the facility transport residents to and from day training? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Senesac & Lennon, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.