

		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>I. IDPH License ID Number: <u>0049718</u></p> <p>Facility Name: <u>GALENA STAUSS NURSING HOME</u></p> <p>Address: <u>215 Summit Street</u> <u>Galena</u> <u>61036</u> Number City Zip Code</p> <p>County: <u>Jo Davies</u></p> <p>Telephone Number: <u>(815) 776-1340</u> Fax # <u>(815) 776-7274</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01-01-70</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>20-4560540</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Tracy Bauer</u> Telephone Number: <u>(815) 776-1340</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>20-4560540</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/2010</u> to <u>9/30/2011</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>Tracy Bauer</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>See Opinion Letter</u> (Print Name and Title) <u>Holly S. Pokrandt, CPA Partner</u> (Firm Name & Address) <u>Wipfli LLP 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u> (Telephone) <u>(715) 858-6627</u> Fax # <u>(715)-832-2345</u></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) _____ (Type or Print Name) <u>Tracy Bauer</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) <u>See Opinion Letter</u> (Print Name and Title) <u>Holly S. Pokrandt, CPA Partner</u> (Firm Name & Address) <u>Wipfli LLP 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u> (Telephone) <u>(715) 858-6627</u> Fax # <u>(715)-832-2345</u>
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Paid Preparer	(Signed) <u>See Opinion Letter</u> (Print Name and Title) <u>Holly S. Pokrandt, CPA Partner</u> (Firm Name & Address) <u>Wipfli LLP 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u> (Telephone) <u>(715) 858-6627</u> Fax # <u>(715)-832-2345</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718 Report Period Beginning: 10/01/2010 Ending: 9/30/2011

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	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,805</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,805</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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF		<u>6,406</u>	<u>882</u>	<u>7,288</u>	8	
9	SNF/PED					9	
10	ICF	<u>10,896</u>			<u>10,896</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>10,896</u>	<u>6,406</u>	<u>882</u>	<u>18,184</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.40%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 5 and days of care provided 882

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 09/30/2011

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

Facility Name & ID Number GALENA STAUSS NURSING HOME # 0049718 Report Period Beginning: 10/01/2010 Ending: 9/30/2011

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	94,699		7,154	101,853		101,853		101,853		1
2	Food Purchase		107,965		107,965		107,965		107,965		2
3	Housekeeping	35,349			35,349		35,349		35,349		3
4	Laundry			39,182	39,182		39,182		39,182		4
5	Heat and Other Utilities			44,489	44,489		44,489		44,489		5
6	Maintenance	22,225		25,942	48,167		48,167		48,167		6
7	Other (specify):*										7
8	TOTAL General Services	152,273	107,965	116,767	377,005		377,005		377,005		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,091,813		61,880	1,153,693		1,153,693		1,153,693		10
10a	Therapy										10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Incontinent Supplies		18,242		18,242		18,242		18,242		15
16	TOTAL Health Care and Programs	1,091,813	18,242	61,880	1,171,935		1,171,935		1,171,935		16
	C. General Administration										
17	Administrative	19,076		15,509	34,585		34,585		34,585		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	29,664		24,117	53,781		53,781		53,781		21
22	Employee Benefits & Payroll Taxes			248,341	248,341		248,341		248,341		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			20,889	20,889		20,889		20,889		26
27	Other (specify):*										27
28	TOTAL General Administration	48,740		308,856	357,596		357,596		357,596		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,292,826	126,207	487,503	1,906,536		1,906,536		1,906,536		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			54,296	54,296	40,331	94,627		94,627			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					43,692	43,692		43,692			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* A & G Allocation			84,023	84,023	(84,023)						36
37	TOTAL Ownership			138,319	138,319		138,319		138,319			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	13,582		770	14,352		14,352		14,352			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,464	31,464		31,464		31,464			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	13,582		32,234	45,816		45,816		45,816			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,306,408	126,207	658,056	2,090,671		2,090,671		2,090,671			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

GALENA STAUSS NURSING HOME

ID# 0049718

Report Period Beginning: 10/01/2010

Ending: 9/30/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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

Facility Name & ID Number

GALENA STAUSS NURSING HOME

0049718

Report Period Beginning:

10/01/2010

Ending:

9/30/2011

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	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number GALENA STAUSS NURSING HOME # 0049718 Report Period Beginning: 10/01/2010 Ending: 9/30/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning: 10/01/2010

10/01/2010

Ending: 1/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

GALENA STAUSS NURSING HOME

0049718

Report Period Beginning:

10/01/2010

Ending:

9/30/2011

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			
A. Directly Facility Related																			
Long-Term																			
1	2007 Bonds		X	Construction of New Hospital		10/1/06	\$ 45,485,000	\$ 45,485,000	10/1/2046	6.7500	\$ 43,692	1							
2				Administration is located in								2							
3				new facility - this portion								3							
4				relates to the NH's portion								4							
5				of the administrative offices.								5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 45,485,000	\$ 45,485,000			\$ 43,692	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 45,485,000	\$ 45,485,000			\$ 43,692	15							

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		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. (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:	2006	_____	8		
	2007	_____	9		
	2008	_____	10		
	2009	_____	11		
	2010	_____	12		
				FOR BHF USE ONLY	
	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GALENA STAUSS NURSING HOME COUNTY Jo Davies

FACILITY IDPH LICENSE NUMBER 0049718

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.	_____	_____	\$ _____	\$ _____
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 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 GALENA STAUSS NURSING HOME

0049718

Report Period Beginning:

10/01/2010 Ending:

9/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,191 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	57	1962	1962	\$ 140,184	\$	47	\$	\$	\$ 140,184
5			1971	172,403		41			172,403
6			1981	57,843	964	Various	964		57,843
7			1988	171,479	13,575	Various	13,575		109,674
8			2007	804,771	40,331	Various	40,331		142,663
Improvement Type**									
9	VARIOUS ADDITIONS	04/01/68		2,826.92		07 00			2,826.92
10	VAR. ADD.	04/01/69		62.76		07 00			62.76
11	VAR. ADD.	04/01/71		7,133.60		07 00			7,133.60
12	VAR. ADD.	04/01/72		229.07		15 00			229.07
13	VAR. ADD.	04/01/73		151.24		10 00			151.24
14	CURB.GUTTER&SDWLK-FRONT ENT	04/01/81		1,002.61		12 00			1,002.61
15	PARKING LOT EXPAN.	04/01/81		7,150.22		12 00			7,150.22
16	LANDSCAPING-HARMS	04/01/83		488.93		10 00			488.93
17	GRAVEL PARKING LOT	04/01/88		3,096.42		05 00			3,096.42
18	SIDEWALK	04/01/88		184.69		10 00			184.69
19	FENCE AROUND CHILLER	04/01/89		225.81		15 00			225.81
20	SIDEWALKS & CEMENT SLAB	04/01/89		801.34		15 00			801.34
21	CHAIN LINK FENCE	04/01/89		330.28		15 00			330.28
22	CONCRETE PARKING LOT	04/01/89		1,375.77		15 00			1,375.77
23	GAZEBO	04/01/89		1,281.54		15 00			1,281.54
24	SIDEWALKS-SPROULE	04/01/90		716.15		15 00			716.15
25	LANDSCAPING	03/31/04		1,209.36	120.94	10 00	120.94		907.02
26	CONCRETE DRIVEWAY	04/01/91		719.54		15 00			719.54
27	LANDSCAPING COURTYARD	04/01/91		1,261.18		10 00			1,261.18
28	PAVE PARKING LOT	04/01/94		1,901.95		12 00			1,901.95
29	PHYSICAL THERAPY/HELIO PAD	04/01/95		2,284.15		08 00			2,284.15
30	14 CAR BUMPERS	04/01/96		222.38		05 00			222.38
31	PARKING LOT	06/01/00		25,238.72	1,682.58	15 00	1,682.58		18,999.15
32	CEDAR PRIVACY FENCE	04/01/01		1,884.61		08 00			1,884.61
33	132 SHRUBS	03/01/02		1,421.00		05 00			1,421.00
34	LANDSCAPING	03/31/02		929.11	92.91	10 00	92.91		882.66
35	2 TREES	03/31/02		131.92	6.60	20 00	6.60		62.66
36	WOODEN FENCE AROUND HVAC	03/31/02		592.52		08 00			592.52

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning:

10/01/2010 Ending:

9/30/2011

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	MOVING/FLATING OF BACKFILL	03/31/02	\$ 1,703.69	\$	05 00	\$	\$	1,703.69	37
38	HANDICAP ENTRANCE	03/31/02	738.77	49.25	15 00	49.25		467.90	38
39	REPAIR TO SIDEWALK (CLINIC/NH)	03/31/02	1,135.67	75.71	15 00	75.71		719.27	39
40	MOVING/FLATTENING OF BACKFILL	11/29/02	373.15		05 00			373.15	40
41	TWO BRONZE PLAQUES	03/20/03	324.15	32.42	10 00	32.42		275.53	41
42	SHRUBS/LANDCAPING/MULCHING	06/05/03	1,672.03	167.20	10 00	167.20		1,421.22	42
43	RESURFACE PARKING LOT	07/08/03	1,391.97	116.00	12 00	116.00		985.98	43
44	LANDSCAPING/SHRUBS/MULCH	07/23/03	406.32	40.63	10 00	40.63		345.37	44
45	PARKING LOT	07/25/05	2,848.40	356.05	08 00	356.05		2,314.34	45
46	LANDSCAPING & PARKING LOT	06/01/00	39,207.46	2,613.83	15 00	2,613.83		29,514.52	46
47	9 SHRUBS	03/31/02	98.38		05 00			98.38	47
48	2 TREES	03/31/02	75.38	3.77	20 00	3.77		35.81	48
49	LANDSCAPING	03/31/02	538.25	53.82	10 00	53.82		511.33	49
50	MULCH	03/31/02	63.64	6.36	10 00	6.36		60.44	50
51	BULLET EDGING	07/31/03	263.85		05 00			263.85	51
52	LANDSCAPING	07/31/03	1,185.42	118.54	10 00	118.54		1,007.61	52
53	SHRUBS	07/31/03	1,377.65		05 00			1,377.65	53
54	VARIOUS ADDITIONS	04/01/62	9,558.00		30 00			9,558.00	54
55	VAR. ADD.	04/01/69	471.15		20 00			471.15	55
56	STOREROOM	04/01/70	11,786.36		42 00			11,786.36	56
57	AIR CONDITIONING	04/01/70	5,136.70		20 00			5,136.70	57
58	AIR CONDITIONING	04/01/74	6,323.55		20 00			6,323.55	58
59	VARIOUS ADDITIONS	04/01/74	1,316.62		35 00			1,316.62	59
60	STOREROOM & MTC-GENERAL	04/01/75	35,866.93		34 00			35,866.93	60
61	STOREROOM & MTC-ELECTRICAL	04/01/75	3,824.97		20 00			3,824.97	61
62	STOREROOM & MTC-MECHANICAL	04/01/75	8,221.55		25 00			8,221.55	62
63	STOREROOM & MTC-SPRINKLER	04/01/75	1,481.30		25 00			1,481.30	63
64	VARIOUS ADDITIONS	04/01/75	111.19		25 00			111.19	64
65	ELECTRICAL 1975 ADDN	04/01/77	267.56		18 00			267.56	65
66	STORM WINDOWS & SCREENS-1962	04/01/77	1,030.51		32 00			1,030.51	66
67	REMODEL X-RAY ROOM	04/01/81	11,234.57		28 00			11,234.57	67
68	HEATING, VENTING, & AIR COND	04/01/82	1,149.61		08 00			1,149.61	68
69	INSULATION	04/01/82	5,661.00		15 00			5,661.00	69
70	TOTAL (lines 4 thru 69)		\$ 1,568,380	\$ 60,407		\$ 60,407	\$	\$ 825,881	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **GALENA STAUSS NURSING HOME**# **0049718**

Report Period Beginning:

10/01/2010

Ending:

9/30/2011**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,568,380	\$ 60,407		\$ 60,407		\$ 825,881	1
2	ENCLOSED PORCH PATIO	04/01/82	2,974.52		15 00			2,974.52	2
3	RENOVATION OF C.S. AREA	04/01/83	1,066.69		20 00			1,066.69	3
4	LIGHT FIXTURES	04/01/84	529.49		10 00			529.49	4
5	VINYL WALL COVERING	04/01/84	3,975.40		10 00			3,975.40	5
6	224 CORRIDOR HANDRAIL	04/01/84	1,435.32		25 00			1,435.32	6
7	DIETARY REMODELING	04/01/84	1,384.42		25 00			1,384.42	7
8	MEDICAL RECORDS REMODELING	04/01/84	603.08		25 00			603.08	8
9	ELECTRICAL WORK	04/01/85	274.99		20 00			274.99	9
10	REMOTE THERMOSTATS	04/01/85	1,586.84		20 00			1,586.84	10
11	WALL COVERINGS	04/01/85	3,768.85		10 00			3,768.85	11
12	GENERAL CONTRACT	04/01/85	32,279.96		24 00			32,279.96	12
13	ELECTRICAL	04/01/85	19,622.56		20 00			19,622.56	13
14	MECHANICAL	04/01/85	29,727.96		20 00			29,727.96	14
15	MILLWORK	04/01/85	11,687.32		20 00			11,687.32	15
16	FLOORING	04/01/85	3,846.53		05 00			3,846.53	16
17	PAINTING	04/01/85	6,442.82		05 00			6,442.82	17
18	NEW ROOM-GIESE	04/01/86	11,425.65		10 00			11,425.65	18
19	REMODELING-NURSERY	04/01/86	222.87		10 00			222.87	19
20	PAINTING-TIEGS	04/01/87	1,551.04		05 00			1,551.04	20
21	12-NEW WINDOWS-GREENCO	04/01/87	3,873.25		12 00			3,873.25	21
22	ROOF REPLACEMENT	04/01/88	1,089.95		10 00			1,089.95	22
23	REMODELING-OLD N.H.	04/01/88	1,307.80		20 00			1,307.80	23
24	FLOOR COVERINGS-BLDG ADD'N	05/01/88	3,859.43		10 00			3,859.43	24
25	PAINTING-BLDG ADD'N	05/01/88	7,643.94		05 00			7,643.94	25
26	MILLWORK-BLDG ADD'N	05/01/88	5,951.75		20 00			5,926.90	26
27	PLUMBING-BLDG ADD'N	05/01/88	24,989.09		20 00			24,884.92	27
28	HEATING & A/C-BLDG ADD'N	05/01/88	24,437.12		20 00			24,335.26	28
29	ELECTRICAL-BLDG ADD'N	05/01/88	29,352.17		20 00			29,229.85	29
30	FIRE ALARM SYSTEM	04/01/89	9,341.71		15 00			9,341.71	30
31	AIR CONDITIONING REPLACEMENT	04/01/89	8,507.01		10 00			8,507.01	31
32	BOILER REPLACEMENT	04/01/89	21,148.21		20 00			21,148.21	32
33	INSULATION	04/01/90	947.65		10 00			947.65	33
34	TOTAL (lines 1 thru 33)		\$ 1,845,235	\$ 60,407		\$ 60,407		\$ 1,102,383	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning:

10/01/2010

Ending:

9/30/2011

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,845,235	\$ 60,407		\$ 60,407	\$	\$ 1,102,383	1
2	NEW DOORS-GREENCO	04/01/90	2,740.43		15 00			2,740.43	2
3	PAINTING-STRUB	04/01/90	601.19		05 00			601.19	3
4	DOOR ALARM SYSTEM	04/01/91	750.24		15 00			750.24	4
5	REMODELING-N.H.	04/01/92	536.10		10 00			536.10	5
6	GARAGE DOOR	04/01/92	513.37		10 00			513.37	6
7	REMODELING-N.H.	04/01/94	2,880.70	144.04	20 00	144.04		2,520.65	7
8	NEW ROOF-GIESE	04/01/94	2,767.36		10 00			2,767.36	8
9	NEW ROOF	04/01/96	20,693.26		10 00			20,693.26	9
10	DRAIN LINE UNDER FLOOR	04/01/96	1,819.16		10 00			1,819.16	10
11	ELECTRICAL-RADIOLOGY REMODEL	04/01/96	13,501.36	750.08	18 00	750.08		11,626.17	11
12	GENERAL-RADIOLOGY REMODELING	04/01/96	31,215.38	1,560.77	20 00	1,560.77		24,191.90	12
13	HELIPORT LIGHTING	04/01/96	1,511.46	50.40	15 00	50.40		1,511.46	13
14	ROOF IMPROVEMENT	04/01/97	855.61		10 00			855.61	14
15	PHYSICAL THERAPY ROOM REMODEL	04/01/97	4,169.28	208.46	20 00	208.46		3,022.74	15
16	HEATING AND A/C UNITS	04/01/99	1,649.24		10 00			1,649.24	16
17	2 STANLEY MAGIC AUTOMATIC DOORS	04/01/99	1,221.23		10 00			1,221.23	17
18	REBUILD CHILLER	04/01/99	3,665.45		10 00			3,665.45	18
19	FIRE ALARM IMPROVEMENTS	04/01/00	1,375.77		10 00			1,375.77	19
20	ARMSTRONG TILE FLOORING FOR DIETARY	04/01/00	1,287.19	64.36	20 00	64.36		740.14	20
21	FIRE ALARM SYSTEM-ADMINISTRATION	04/01/01	904.61	60.31	15 00	60.31		633.23	21
22	REMODELING-BUSINESS OFFICE	04/01/01	63,450.62	4,230.04	15 00	4,230.04		44,415.43	22
23	HOOD & EXHAUST WORK - DIETARY	04/01/01	906.50	45.32	20 00	45.32		475.91	23
24	RADIOLOGY REMODEL	03/31/02	23,994.87	1,599.66	15 00	1,599.66		15,196.75	24
25	NURSING HOME NEW CEILING	03/31/02	2,788.47	278.85	10 00	278.85		2,649.05	25
26	NURSING HOME SHOWER FLOORS	03/31/02	471.15	23.56	20 00	23.56		223.80	26
27	CARPET-HALLWAY	03/31/02	5,451.05		05 00			5,451.05	27
28	NURSING HOME REMODEL	11/04/02	3,088.20	308.82	10 00	308.82		2,624.97	28
29	NURSING HOME CARPET	11/20/02	4,742.06		05 00			4,742.06	29
30	NURSING HOME THERMOSTATS & ELECTRIC	01/09/03	2,427.52	242.75	10 00	242.75		2,063.40	30
31	AUTOMATIC ENTRANCE MED-SURG	01/28/03	7,500.75		05 00			7,500.75	31
32	ADMINISTRATION REMODEL	03/26/03	5,490.44	366.03	15 00	366.03		3,111.25	32
33	NURSING HOME FIRE DOOR	03/31/03	1,309.81	130.98	10 00	130.98		1,113.33	33
34	TOTAL (lines 1 thru 33)		\$ 2,061,515	\$ 70,471		\$ 70,471	\$	\$ 1,275,385	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning:

10/01/2010 Ending:

9/30/2011

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,061,515	\$ 70,471		\$ 70,471	\$	\$ 1,275,385	1
2	HOSPITAL GENERATOR POWER SOURCE	03/31/03	4,989.70		05 00			4,989.70	2
3	ELECTRICAL WORK	10/31/03	3,736.05	186.80	20 00	186.80		1,401.02	3
4	WATER HEATERS	10/31/03	844.34	84.43	10 00	84.43		633.26	4
5	FLOORING	10/31/03	927.34		05 00			927.34	5
6	DENSITOMETER ROOM	03/31/04	4,102.37		05 00			4,102.37	6
7	CIRCULATING BOOSTER PUMP	04/30/04	2,708.19	270.82	10 00	270.82		2,031.14	7
8	PT REMODEL	05/01/04	8,043.91	536.26	15 00	536.26		4,021.97	8
9	AUTOMATIC DOOR	07/01/04	778.34	77.83	10 00	77.83		583.76	9
10	CT REMODEL	05/20/05	58,449.96	2,922.50	20 00	2,922.50		18,996.23	10
11	CARPET-EDUCATION ROOM	07/19/05	463.61		05 00			463.61	11
12	WOOD FLOORING-DINING ROOMS	07/19/05	781.17	78.12	10 00	78.12		507.76	12
13	MAMMOGRAM ROOM REMODEL	08/30/05	3,430.37	228.69	15 00	228.69		1,486.49	13
14	REMODELING-GENERAL	04/01/94	52,849.58	1,957.39	27 00	1,957.39		34,254.35	14
15	PLUMBING	04/01/94	4,680.12	234.00	20 00	234.00		4,095.08	15
16	HEATING, VENTING, AIR COND.	04/01/94	11,049.06	552.46	20 00	552.46		9,667.96	16
17	ELECTRICAL	04/01/94	21,536.50	1,076.83	20 00	1,076.83		18,844.45	17
18	PAINTING	04/01/94	649.96		10 00			649.96	18
19	SUSPENDED CEILING	04/01/94	2,919.13		12 00			2,919.13	19
20	CABINETS	04/01/94	7,331.93	366.60	20 00	366.60		6,415.47	20
21	FLOOR COVERINGS	04/01/94	4,840.01		10 00			4,840.01	21
22	ELEVATOR	04/01/94	11,875.62	593.78	20 00	593.78		10,391.16	22
23	HAND RAIL FOR PHYSICAL THERAPY	12/17/02	303.05	20.20	15 00	20.20		171.73	23
24	EXTENSION JOINT	11/03/04	530.02		05 00			530.02	24
25	ELEVATOR PROCESSOR BOARD	12/01/05	980.55	32.69	05 00	32.69		972.38	25
26	ER REMODEL/SHOWER ROOM	01/01/06	1,670.97	111.40	15 00	111.40		635.91	26
27	GARAGE DOOR	07/01/06	436.17	43.62	10 00	43.62		227.17	27
28	FLOORING	09/22/06	232.75	23.27	10 00	23.27		128.01	28
29	HEATING	09/30/07	2,125.84	141.72	15 00	141.72		637.75	29
30	SPRINKLER SYSTEM	09/30/07	22,633.43	905.34	25 00	905.34		4,074.02	30
31	SPRINKLER SYSTEM	09/30/07	2,220.07	88.80	25 00	88.80		399.61	31
32	HVAC UNIT	09/30/07	7,043.55	469.57	15 00	469.57		2,113.06	32
33	PLASTIC CULVERT PIPE	09/30/07	1,470.00	73.50	20 00	73.50		330.75	33
34	TOTAL (lines 1 thru 33)		\$ 2,308,148	\$ 81,548		\$ 81,548	\$	\$ 1,417,828	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 2,308,148	\$ 81,548		\$ 81,548		\$ 1,417,828		1
2	Building Components/Remodeling - 2007 Nursing Home	12/05/07	1,380.48	69.03	20 00	69.03	264.60		2
3	Deck	09/30/10	4,997.61	499.76	10 00	499.76	749.64		3
4	Flooring	09/30/10	420.49	42.05	10 00	42.05	63.07		4
5	Windows and Doors	09/30/10	5,307.07	265.35	20 00	265.35	398.03		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	TOTAL (lines 1 thru 33)	\$ 2,320,254	\$ 82,424		\$ 82,424	\$	\$ 1,419,303		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning:

10/01/2010

Ending:

9/30/2011

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	\$ 89,241	\$ 9,060	\$ 9,060			\$ 68,416	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	183,545	3,143	3,143			183,545	73
74								74
75	TOTALS	\$ 272,786	\$ 12,203	\$ 12,203			\$ 251,961	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)	\$ 2,593,040	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,627	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,627	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)	\$ 1,671,264	85

**

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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. _____ /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 checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	line 39 col 4	494.50 hrs	13,582			770	495	14,352	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			\$ 13,582		\$	\$ 770	495	\$ 14,352	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/2011**

(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	\$ 1,629,875	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>771,300</u>)	2,576,105		3
4	Supply Inventory (priced at <u>cost</u>)	285,077		4
5	Short-Term Investments	1,535,119		5
6	Prepaid Insurance	4,465		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,030,641	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,920,543		12
13	Land	559,916		13
14	Buildings, at Historical Cost	42,678,313		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	9,036,552		16
17	Accumulated Depreciation (book methods)	(17,040,430)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,059		21
22	Other Long-Term Assets (spe <u>Intangible Asset</u>)	9,496		22
23	Other(specify): <u>Bond issuance costs</u>	842,469		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 42,010,918	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 48,041,559	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 623,154	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,000		29
30	Accrued Salaries Payable	479,844		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,535,119		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Security deposits held</u>	90,050		36
37	<u>Amounts payable to Medicare</u>	1,335,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,413,167	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	45,135,000		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)	\$ 45,135,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 49,548,167	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,506,608)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 48,041,559	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 408,808	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 408,808	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,904,122)	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) Temp restricted contributions and income	4,042	15
16	Other (describe) Loans forgiven from Temp Restricted Net Assc	(15,336)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,915,416)	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)	\$ (1,506,608)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning: 10/01/2010

Ending: 9/30/2011

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	\$ 3,385,474	1
2	Discounts and Allowances for all Levels	(1,103,675)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,281,799	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,856	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 85,856	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,367,655	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	377,005	31
32	Health Care	1,171,935	32
33	General Administration	357,596	33
B. Capital Expense			
34	Ownership	138,319	34
C. Ancillary Expense			
35	Special Cost Centers	14,352	35
36	Provider Participation Fee	31,464	36
D. Other Expenses (specify):			
37	Hospital Net Loss	2,181,106	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,271,777	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,904,122)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,904,122)	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning: 10/01/2010

Ending:

9/30/2011

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	2,147	2,167	\$ 67,119	\$ 30.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,106	8,182	170,309	20.82	3
4	Licensed Practical Nurses	9,388	9,476	187,325	19.77	4
5	CNAs & Orderlies	45,809	46,240	555,453	12.01	5
6	CNA Trainees					6
7	Licensed Therapist	495	499	13,710	27.47	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,854	3,890	34,061	8.76	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	1,641	1,656	52,262	31.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward clerk</u>	2,032	2,051	23,581	11.50	33
34	TOTAL (lines 1 - 33)	73,472	74,161	\$ 1,103,820 *	\$ 14.88	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			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)	\$		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
_____	_____	_____	\$ _____	Workers' Compensation Insurance	\$ _____	IDPH License Fee	\$ _____	
_____	_____	_____	_____	Unemployment Compensation Insurance	_____	Advertising: Employee Recruitment	_____	
_____	_____	_____	_____	FICA Taxes	_____	Health Care Worker Background Check	_____	
_____	_____	_____	_____	Employee Health Insurance	_____	(Indicate # of checks performed _____)	_____	
_____	_____	_____	_____	Employee Meals	_____	Patient Background Checks	_____	
_____	_____	_____	_____	Illinois Municipal Retirement Fund (IMRF)*	_____	_____	_____	
_____	_____	_____	_____	_____	_____	_____	_____	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ _____	_____	_____	_____	_____	
(List each licensed administrator separately.)			_____	_____	_____	_____	_____	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount	Description			Amount	
_____			\$ _____	Less: Public Relations Expense			(_____)	
_____			_____	Non-allowable advertising			(_____)	
_____			_____	Yellow page advertising			(_____)	
_____			_____	TOTAL (agree to Sch. V, line 20, col. 8)			\$ _____	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)			_____	Description			Description	
C. Professional Services				Line #			Amount	
Vendor/Payee		Type	Amount	Amount			Amount	
_____		_____	\$ _____	_____			Out-of-State Travel	
_____		_____	_____	_____			\$ _____	
_____		_____	_____	_____			_____	
_____		_____	_____	_____			In-State Travel	
_____		_____	_____	_____			_____	
_____		_____	_____	_____			Seminar Expense	
_____		_____	_____	_____			_____	
_____		_____	_____	_____			Entertainment Expense	
_____		_____	_____	_____			(_____)	
_____		_____	_____	_____			TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)		_____	\$ _____	TOTAL			\$ _____	
(If total legal fees exceed \$5,000, attach copy of invoices.)		_____	_____	_____			_____	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2007					FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GALENA STAUSS NURSING HOME

0049718

Report Period Beginning: 10/01/2010

Ending: 9/30/2011

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? Yes If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,242 Line 15
- (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. \$ 31,464
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? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Wipfli 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? No
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT