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.

I. IDPH License ID Number: 0014464

Facility Name: Iroquois Resident Home

Address: 200 East Fairman Avenue (Number) Watseka, IL (City) 60970 (Zip Code)

County: Iroquois County

Telephone Number: 815-432-5841 **Fax #** 815-432-7870

HFS ID Number:

Date of Initial License for Current Owners: 08/18/2003

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Tom McCann **Telephone Number:** 815-432-7720
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/10 to 9/30/11 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) David Schnake, Partner
(Firm Name & Address) Kerber, Eck, & Braeckel LLP, 1116 West Main Street, Carbondale, IL 62901
(Telephone) 618-529-1040 Fax # 618-549-2311

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

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	35	Skilled (SNF)	35	12,775	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	35	TOTALS	35	12,775	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		7,171	2,224	9,395	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		7,171	2,224	9,395	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.54%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 1958

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 44 and days of care provided 2,224

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/11 Fiscal Year: 09/30/11

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

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	4,923		8,033	12,956		12,956	218,834	231,790			1
2	Food Purchase							64,052	64,052			2
3	Housekeeping			810	810		810	40,254	41,064			3
4	Laundry			37,810	37,810		37,810	44,321	82,131			4
5	Heat and Other Utilities							38,031	38,031			5
6	Maintenance			6,096	6,096		6,096	72,786	78,882			6
7	Other (specify):*											7
8	TOTAL General Services	4,923		52,749	57,672		57,672	478,278	535,950			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	937,091	21,977	6,647	965,715		965,715	24,030	989,745			10
10a	Therapy	16,498		3,646	20,144		20,144		20,144			10a
11	Activities	37,682		2,438	40,120		40,120		40,120			11
12	Social Services	2,812		3,959	6,771		6,771		6,771			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	994,083	21,977	16,690	1,032,750		1,032,750	24,030	1,056,780			16
	C. General Administration											
17	Administrative							99,393	99,393			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			11,805	11,805		11,805		11,805			20
21	Clerical & General Office Expenses	26,774	30,949	2,224	59,947		59,947	136,616	196,563			21
22	Employee Benefits & Payroll Taxes			66,985	66,985		66,985	125,413	192,398			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,302	1,302		1,302		1,302			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	26,774	30,949	82,316	140,039		140,039	361,422	501,461			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,025,780	52,926	151,755	1,230,461		1,230,461	863,730	2,094,191			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Iroquois Resident Home #0014464 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			55,098	55,098		55,098		55,098			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,422	1,422		1,422		1,422			35
36	Other (specify):*											36
37	**TOTAL Ownership**			56,520	56,520		56,520		56,520			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		11,274		11,274		11,274		11,274			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			24,090	24,090		24,090		24,090			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		11,274	24,090	35,364		35,364		35,364			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,025,780	64,200	232,365	1,322,345		1,322,345	863,730	2,186,075			45

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

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Lobbying	(501)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (501)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	864,231		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 864,231		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 863,730		37

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

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

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

Iroquois Resident Home

ID# 0014464

Report Period Beginning: 10/1/10

Ending: 9/30/11

	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	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Iroquois Resident Home # 0014464 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Iroquois Resident Home # 0014464 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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
Iroquois Memorial Hospital	100				Watseka, IL	Hospital
				Iroquois Home Care	Watseka, IL	DME retailer

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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.**

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	Dennis Wittenborn	BOD						1
2	Steven Knapp	BOD						2
3	Cindy Sumner	BOD						3
4	Maggie Martin	BOD						4
5	Roger Ball	BOD						5
6	Mel Ward	BOD						6
7	Dan Tincher	BOD						7
8	Philip Zumwaldt, M.D.	BOD						8
9	Roger Dittrich	BOD						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 Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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 [X] NO [ ]

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

Name of Related Organization: Iroquois Memorial Hospital
Street Address: 200 Fairman Ave
City / State / Zip Code: Watseka, IL 60970
Phone Number: (815)432-5841
Fax Number: (815)432-7870

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Gross Salaries	15,890,156		$ 1,949,505	$ 0	1,022,225	$ 125,413	1
2	21	Employee Benefits-Salary	Gross Salaries	15,890,156		143,721	143,721	1,022,225	9,246	2
3	21	Admitting	Gross Charges	67,092,855		528,308	291,327	1,724,696	13,581	3
4	10	Purchasing, Rec, & Stores	Costed Req's	3,017,434		158,192	102,348	52,926	2,775	4
5	21	Data Processing	Time Spent	681,606		734,558	271,510	62,071	66,893	5
6	21	Communications	# of Phones	227		268,988	0	9	10,665	6
7	21	Business Office	Gross Charges	67,092,855		322,801	163,438	1,724,696	8,298	7
8	17	Admin and General	Accum Cost	31,277,414		1,986,929	276,357	1,564,606	99,393	8
9	5	Heat	Square Feet	109,936		427,019	0	9,791	38,031	9
10	6	Maintenance	Square Feet	109,936		817,259	226,060	9,791	72,786	10
11	4	Laundry	Pounds	383,025		121,523	44,506	139,695	44,321	11
12	3	Housekeeping	Square Feet	106,957		439,739	269,152	9,791	40,254	12
13	1	Dietary	Meals	47,488		388,196	188,047	26,770	218,834	13
14	2	Food	Meals	47,488		113,624	0	26,770	64,052	14
15	21	Cafeteria	FTEs	27,938		266,212	175,188	2,984	28,434	15
16	10	Medical Records	Gross Charges	73,344,165		903,888	449,997	1,724,696	21,255	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,570,462	$ 2,601,651		$ 864,231	25

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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

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

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

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

Facility Name & ID Number Iroquois Resident Home **#** 0014464 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Iroquois Resident Home COUNTY Iroquois County

FACILITY IDPH LICENSE NUMBER 0014464

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,791 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

Hospital (49 Beds), Home Health, Hospice, Rural Health Clinics, Clinics

Total other square feet-125,593

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		9,791	1958	$ 57,278	1
2					2
3	TOTALS	9,791		$ 57,278	3

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	35		1958	1958	$ 296,212	$	40	$	$	$ 296,212	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFING			1976	27,273		20			27,273	9
10	CENTRAL A/C			1976	108,539		15			108,539	10
11	SPRINKLER SYSTEM			1977	20,560		20			20,560	11
12	5 DOOR SENSORS			1986	5,087		10			5,087	12
13	INSULATION WORK			1987	56,995		10			56,995	13
14	SEAL & WATERPROOF			1988	6,517		10			6,517	14
15	PAINT & WALLPAPER HALLS			1989	5,363		5			5,363	15
16	FLOORING			1989	6,243		10			6,243	16
17	ARCHITECT FEES			1990	500		15			500	17
18	LAND PREP RH GARDEN			1990	3,935		20			3,935	18
19	SHELVING			1990	619		20			619	19
20	SHELVING			1990	619		20			619	20
21	PAINTING, WALLPAPER, ETC.			1990	5,250		5			5,250	21
22	REMODELING			1990	6,684		10			6,684	22
23	PATIO MASONRY WORK			1991	45,275	1,131	20	1,131		45,275	23
24	IRRIGATION			1991	3,900		15			3,900	24
25	LANDSCAPING			1992	3,754	188	20	188		3,661	25
26	FENCING			1992	2,111	106	20	106		2,059	26
27	FENCING			1992	2,595	130	20	130		2,532	27
28	PAVILLIONN			1992	6,540	327	20	327		6,377	28
29	GUTTERS			1992	1,200		15			1,200	29
30	LIGHTING			1992	7,000		15			7,000	30
31	PAINTING & PAPERING			1992	9,245		5			9,245	31
32	PARKING LOT NE			1995	58,302	2,915	20	2,915		48,099	32
33	GARDEN SIDEWALK			1995	2,480		15			2,480	33
34	8 X 8 PPAIR ALUM DOORS			1995	3,093		10			3,093	34
35	PINE HAND RAILS			1995	383		10			383	35
36	ARCH FEES			1995	19,585	1,306	15	1,306		17,628	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LOT LIGHT POLE FEED	1996	$ 1,081	$ 54	20	$ 54	$	$ 837	37
38	PARKING LOT	1997	144,218	7,211	20	7,211		104,559	38
39	LANDSCAPING	1998	7,810		10			7,810	39
40	CUBICAL CURTAINS (80)	1999	32,980		5			32,980	40
41	REMODELING RH	1999	17,488		5			17,488	41
42	#2529 HOM DELTA LAU FAUCETS (14)	1999	2,085	104	20	104		1,301	42
43	REMODELING RESTROOMS	1999	69,743	3,487	20	3,487		43,589	43
44	TILE	1999	22,658		5			22,658	44
45	GIFT HAND RAIL 1.5 ROUND	1999	1,708	114	15	114		1,310	45
46	RH REMODELING	1999	27,360	1,824	15	1,824		20,976	46
47	SIDEWALKS	1999	833	56	15	56		639	47
48	NURSE CALL SYSTEM	1999	13,747		10			13,747	48
49	SIDE WALKS W & S	1999	2,305	154	15	154		1,923	49
50	OAK CABINETS	2000	6,160	411	15	411		4,724	50
51									51
52	BEDS	1998	57,478		12			57,478	52
53	FLOOR TILE	2000	19,932	1,329	15	1,329		15,282	53
54	RH REMODELING	2000	1,360		5			1,360	54
55	ASBESTOS PROGRAM	2000	6,212		5			6,212	55
56	LIGHTS & WIRING	2000	5,885	392	15	392		4,510	56
57	ARCH FEES	2000	580		5			580	57
58	RH REMODELING	2000	45,000	3,000	15	3,000		34,500	58
59	RH - REMODELING & PAINT	2001	356		5			356	59
60	RH REMODELING - COUNTER TOPS (16)	2001	1,794	90	20	90		944	60
61	HEADS IN REST ROOMS (4)	2001	735	37	20	37		387	61
62	FAUCETS (3)	2001	517	26	20	26		272	62
63	CERAMIC TILE & FLOOR FIVE ROOMS	2001	4,650	233	20	233		2,442	63
64	REMODELING - ELECTRICAL (8 ROOMS)	2004	2,524	168	15	168		1,765	64
65	RH-REMODELING ELECTRICAL	2001	43,796	2,920	15	2,920		30,659	65
66	CABINETS, 8 DRAWER OAK	2002	2,710	181	15	181		1,718	66
67	FAN COIL UNIT	2002	11,469	765	15	765		7,265	67
68	REMODELING RH	2002	81,294	5,420	15	5,420		51,487	68
69	ARCH FEES	2003	13,259		5			13,259	69
70	TOTAL (lines 4 thru 69)		$ 1,365,586	$ 34,076		$ 34,076	$	$ 1,208,344	70

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

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,365,586	$ 34,076		$ 34,076	$	$ 1,208,344	1
2	DOOR & FRAME	2003	6,665	444	15	444		3,776	2
3	RH-IDPH	2003	7,027		5			7,027	3
4	RH-IDPH	2003	8,376		5			8,376	4
5	LEVEL & LOCK ANDERSON LOCK	2004	4,965	497	10	497		3,724	5
6	SCONCES & HANGING PENDANT BELLACOR	2004	5,875	392	15	392		2,938	6
7	PAINTING (DEXTER DECORATING)	2004	13,848		5			13,848	7
8	PLUMBING (JENTER INC)	2004	32,604	1,630	20	1,630		12,226	8
9	ENTRE WHITE CABINETRY & VINIONEER TOS	2004	5,663	378	15	378		2,832	9
10	FLOORING - KINDON'S	2004	14,315	954	15	954		7,157	10
11	PENNER PT CARE-CASCADE WHIRPOOL SYST	2004	13,695	1,370	10	1,370		10,272	11
12	REMODELING RH	2004	45,388	3,026	15	3,026		22,695	12
13	CERAMIC TIME	2004	28,590	1,430	20	1,430		10,722	13
14	CARPET SHAW	2004	17,968		5			17,968	14
15	FIXTURES	2004	13,017	1,302	10	1,302		9,764	15
16	MISC REMODELING - RH	2004	7,104	710	10	710		5,327	16
17	SMOKE DETECTOR - IDPH - SIMPLEX	2004	4,201	420	10	420		3,151	17
18	NURSES STATION	2004	23,000	2,300	10	2,300		17,250	18
19	CHART RACK CABINET	2004	2,317	116	20	116		869	19
20	PIPE RH CHILLED WATER LOOP	2005	8,450	338	25	338		2,197	20
21	WANDER GUARD SYSTEM	2006	13,663	1,366	10	1,366		7,515	21
22	CONCRETE SIDEWALK AND HAND RAILS	2009	12,760	851	15	851		2,127	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)		$ 1,655,077	$ 51,599		$ 51,599	$	$ 1,380,103	34

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

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	$ 52,634	$ 3,499	$ 3,499	$		$ 32,980	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	77,125					77,125	73
74								74
75	TOTALS	$ 129,759	$ 3,499	$ 3,499	$		$ 110,105	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)	$ 1,842,114	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,098	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,098	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)	$ 1,490,208	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.

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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: ____ *

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	$

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

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

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

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a,3	52	hrs	3,646				52	3,646	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							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				$ 3,646		$	$	52	$ 3,646	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.

STATE OF ILLINOIS

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 960,793	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	62,474	4,013,096	3
4	Supply Inventory (priced at)		1,077,655	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		977,468	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 62,474	$ 7,029,012	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,687,399	12
13	Land	57,278	249,035	13
14	Buildings, at Historical Cost	1,655,077	23,210,275	14
15	Leasehold Improvements, at Historical Cost		477,850	15
16	Equipment, at Historical Cost	129,759	13,235,670	16
17	Accumulated Depreciation (book methods)	(1,490,208)	(23,737,386)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe IHC, Ben. Int., bd cost		6,314,276	22
23	Other(specify): CIP		86,564	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 351,906	$ 21,523,683	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 414,380	$ 28,552,695	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,702,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		1,287,135	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 2,989,394	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		688,000	39
40	Mortgage Payable			40
41	Bonds Payable		4,865,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Asset Retirement Obligation		291,437	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,844,437	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 8,833,831	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 414,380	$ 19,718,864	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 414,380	$ 28,552,695	48

*(See instructions.)

Facility Name & ID Number Iroquois Resident Home **#** 0014464 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 316,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 316,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	98,140	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 98,140	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)**	$ 414,380	24 *

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

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,722,877	1
2	Discounts and Allowances for all Levels	(302,392)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,420,485	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,420,485	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	62,342	31
32	Health Care	1,028,080	32
33	General Administration	140,039	33
	B. Capital Expense		
34	Ownership	56,520	34
	C. Ancillary Expense		
35	Special Cost Centers	35,364	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,322,345	40
41	**Income before Income Taxes (line 30 minus line 40)****	98,140	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 98,140	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 Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,029	2,029	$ 66,364	$ 32.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,643	7,643	202,307	26.47	3
4	Licensed Practical Nurses	13,196	13,196	277,447	21.03	4
5	CNAs & Orderlies	33,025	33,025	390,973	11.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	871	871	16,498	18.94	8
9	Activity Director	3,030	3,030	37,682	12.44	9
10	Activity Assistants					10
11	Social Service Workers	126	126	2,812	22.32	11
12	Dietician	48	48	4,923	102.56	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					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,103	2,103	26,774	12.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	62,071	62,071	$ 1,025,780 *	$ 16.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas McCann	Administrator		$
(salary included in overhead-			
none of his salary is allocated			
directly to the resident home)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	66,985
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Medicare cost report expense (allocated	
benefits)	125,413
TOTAL (agree to Schedule V, line 22, col.8)	$ 192,398

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
MDS Software support	5,280
Illinosi Health Care Assn	1,417
Newpaper/Magazine/online book sub	929
MDS Alert	199
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,805

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,302
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,302

**See instructions.

Facility Name & ID Number Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/10 Ending: 9/30/11

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Iroquois Resident Home **#** 0014464 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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? **Yes**
If YES, give association name and amount. **Ill Health Care Assc $1,417**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $501**

(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? **35**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **N/A-1st yr** 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. $ **24,090**
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? **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. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Kerber, Eck, & Braeckel, 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.