

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0004259</u></p> <p><b>Facility Name:</b> <u>Stephenson Nursing Center</u></p> <p><b>Address:</b> <u>2945 South Walnut</u> <u>Freeport</u> <u>61032</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Stephenson</u></p> <p><b>Telephone Number:</b> <u>815-235-6173</u> <b>Fax #</b> <u>815-235-1309</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1/1/1971</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Penny Smith</u> <b>Telephone Number:</b> <u>815-235-6173</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/10</u> to <u>11/30/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="3" style="width:15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Darnell Fortney</u> (Date) _____</td> </tr> <tr> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td rowspan="5" style="width:15%;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Rob Schlicht</u> <u>Director</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee WI 53226</u></td> </tr> <tr> <td>(Telephone) <u>(414) 431-9335</u> Fax # <u>(414) 431-9303</u></td> </tr> <tr> <td>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</td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Darnell Fortney</u> (Date) _____	(Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) <u>Rob Schlicht</u> <u>Director</u>	(Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee WI 53226</u>	(Telephone) <u>(414) 431-9335</u> Fax # <u>(414) 431-9303</u>	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
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																																	
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Facility Name & ID Number Stephenson Nursing Center

# 0004259 Report Period Beginning: 12/1/10 Ending: 11/30/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3	2	Intermediate (ICF)	2	730	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,365	1,964		3,329	8
9	SNF/PED					9
10	ICF	31,439	6,561	1,654	39,654	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,804	8,525	1,654	42,983	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.69%

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 01/01/1961

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 160 and days of care provided 3,152

Medicare Intermediary WPS Medicare

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/10 Ending: 11/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary		806	742,590	743,396	(11,447)	731,949	(4,275)	727,674		1
2	Food Purchase										2
3	Housekeeping	146,808	(2,340)	2,608	147,076		147,076		147,076		3
4	Laundry	110,182	49,830		160,012		160,012		160,012		4
5	Heat and Other Utilities			151,537	151,537		151,537		151,537		5
6	Maintenance	95,057	131,796		226,853		226,853		226,853		6
7	Other (specify):* <b>Central Supp/NC</b>	18,525			18,525		18,525		18,525		7
8	<b>TOTAL General Services</b>	370,572	180,092	896,735	1,447,399	(11,447)	1,435,952	(4,275)	1,431,677		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,700	6,700		6,700		6,700		9
10	Nursing and Medical Records	2,187,880	194,710	433,132	2,815,722		2,815,722		2,815,722		10
10a	Therapy										10a
11	Activities	119,279	1,045		120,324		120,324		120,324		11
12	Social Services	70,831			70,831		70,831		70,831		12
13	CNA Training										13
14	Program Transportation		2,665		2,665		2,665		2,665		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,377,990	198,420	439,832	3,016,242		3,016,242		3,016,242		16
	<b>C. General Administration</b>										
17	Administrative	157,861			157,861		157,861	28,929	186,790		17
18	Directors Fees										18
19	Professional Services			6,787	6,787		6,787		6,787		19
20	Dues, Fees, Subscriptions & Promotions			16,381	16,381		16,381	(10,244)	6,137		20
21	Clerical & General Office Expenses	115,758	36,719	15,102	167,579		167,579		167,579		21
22	Employee Benefits & Payroll Taxes			629,335	629,335	11,447	640,782	556,967	1,197,749		22
23	Inservice Training & Education			262	262		262		262		23
24	Travel and Seminar			2,380	2,380		2,380		2,380		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							49,236	49,236		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	273,619	36,719	670,247	980,585	11,447	992,032	624,888	1,616,920		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,022,181	415,231	2,006,814	5,444,226		5,444,226	620,613	6,064,839		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 Stephenson Nursing Center

#0004259

Report Period Beginning:

12/1/10

Ending:

11/30/11

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			87,525	87,525		87,525		87,525			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			87,525	87,525		87,525		87,525			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,277		148,277		148,277		148,277			39
40	Barber and Beauty Shops		372		372		372		372			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							35,480	35,480			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		148,649		148,649		148,649	35,480	184,129			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,022,181	563,880	2,094,339	5,680,400		5,680,400	656,093	6,336,493			45

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



Stephenson Nursing Center

ID# 0004259

Report Period Beginning: 12/1/10

Ending: 11/30/11

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Stephenson Nursing Center

# 0004259

Report Period Beginning:

12/1/10

Ending:

11/30/11

## 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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(4,275)	0	0	0	0	0	0	0	0	0	0	(4,275)	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	<b>TOTAL General Services</b>	<b>(4,275)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,275)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	28,929	0	0	0	0	0	0	0	0	0	28,929	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	(10,244)	0	0	0	0	0	0	0	0	0	0	(10,244)	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	556,967	0	0	0	0	0	0	0	0	0	556,967	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	49,236	0	0	0	0	0	0	0	0	0	49,236	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(10,244)</b>	<b>635,132</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>624,888</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(14,519)</b>	<b>635,132</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>620,613</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stephenson Nursing Center# 0004259

Report Period Beginning:

12/1/10

Ending:

11/30/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(14,519)</b>	<b>635,132</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>620,613</b>	<b>45</b>



Facility Name & ID Number

Stephenson Nursing Center

# 0004259

Report Period Beginning:

12/1/10

Ending:

11/30/11

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

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	22 Employee Benefits	\$			\$ 556,967	\$	556,967	1
2	V	26 Insurance				49,236		49,236	2
3	V	17 County Administrator				22,002		22,002	3
4	V	17 County Treasurer				939		939	4
5	V	17 County Clerk				2,777		2,777	5
6	V	17 County Board				2,072		2,072	6
7	V	17 County Courthouse				1,139		1,139	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			\$ 635,132	\$ *	635,132	14

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



Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/10 Ending: 11/30/11

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Stephenson Nursing Center

# 0004259

Report Period Beginning:

12/1/10

Ending: 11/30/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Stephenson Nursing Center

# 0004259

Report Period Beginning:

12/1/10

Ending:

11/30/11

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

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2010 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	_____	8
	2007	_____	9
	2008	_____	10
	2009	_____	11
	2010	_____	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

# 2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stephenson Nursing Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0004259

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Stephenson Nursing Center

# 0004259

Report Period Beginning:

12/1/10

Ending:

11/30/11

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 54,954 B. General Construction Type: Exterior Block & Cement 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).

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Facility</u>	<u>392,040</u>	<u>1853</u>	\$	<u>1</u>
2					<u>2</u>
3	TOTALS	392,040		\$	3



Facility Name &amp; ID Number Stephenson Nursing Center

# 0004259

Report Period Beginning:

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**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	98		1971		\$ 613,691	\$ 3	40	\$ 3		\$ 613,691	4
5	66		1988		1,687,286	42,182	40	42,182		991,280	5
6	Alzheimers Unit		1993		189,427	4,736	40	4,736		86,427	6
7	Garage Building		1972		2,912		20			2,912	7
8	Building		1984		149,592	3,740	40	3,740		98,114	8
	Improvement Type**										
9	Improvement		1980		15,878		10			15,878	9
10	boiler reparis		1981		1,000		15			1,000	10
11	roof repairs		1981		10,634		20			10,634	11
12	sidewalks		1982		1,276		20			1,276	12
13	Improvement		1983		2,555		25			2,555	13
14	Improvement		1987		3,816		15			3,816	14
15	Improvement		1989		27,483	687	40	687		15,459	15
16	Improvement		1992		8,038		10			8,038	16
17	Improvement		1981		1,110		10			1,110	17
18	Improvement		1994		8,557	214	40	214		3,655	18
19	Improvement		1994		8,991		40			8,991	19
20	Improvement		1995		8,258	206	40	206		3,416	20
21	parking lot expansion		1995		10,659	533	20	533		8,282	21
22	water heater		1996		2,475		20			2,475	22
23	water heater		1996		3,449		10			3,449	23
24	fire dampers		1996		744	30	25	30		457	24
25	parking lot expansion		1996		26,914	1,346	20	1,346		19,569	25
26	roof top air/heat units		1997		14,936		25			14,936	26
27	smoke detectors		1997		2,248		10			2,248	27
28	carpeting & vinyl		1997		3,828		10			3,828	28
29	roof top air/heat units		1998		14,997		10			14,997	29
30	water heater/sprinkling system		1998		17,742		10			17,742	30
31	carpeting & vinyl		1998		3,449		10			3,449	31
32	blacktopping		1971		6,755		10			6,755	32
33	roof		1979		11,804		10			11,804	33
34	roof		1978		9,092		10			9,092	34
35	roof		1978		4,546		10			4,546	35
36											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 &amp; ID Number Stephenson Nursing Center

# 0004259

Report Period Beginning:

12/1/10

Ending:

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## 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	Tuckpointing	1975	\$ 2,700	\$ 26	35	\$ 26		\$ 2,700	37
38	fire doors	1975	4,443	53	35	53		4,443	38
39	plaster	1976	917	22	35	22		917	39
40	alarm system	1976	350	10	35	10		350	40
41	fire alarm	1983	1,360		10			1,360	41
42	alarm system	1990	11,316		10			11,316	42
43	water softner	1990	9,178		10			9,178	43
44	dehumidifier	1990	9,500		10			9,500	44
45	ansul fire door	1999	1,374		10			1,374	45
46	roof a/c unit	1999	11,080		10			11,080	46
47	paving	2000	7,942	318	25	318		3,654	47
48	smoke wall	2000	13,973	699	20	699		8,036	48
49	boiler	2001	4,752	475	10	475		4,752	49
50	steel door	2001	568	14	40	14		149	50
51	block heater	2002	655	66	10	66		621	51
52	temperature control	2002	1,000	100	10	100		860	52
53	manhole for sewer	2002	4,800	480	10	480		4,560	53
54	fence	2003	4,220	422	10	422		3,587	54
55	boiler and installation	2004	4,961	496	10	496		3,720	55
56	doors and frames	2008	10,520	1,052	10	1,052		3,156	56
57	Vinyl kitchen wall	2009	2,056	51	40	51		153	57
58	Kitchen doors and hardware	2009	3,617	90	40	90		270	58
59	Kitchen floor	2009	14,517	363	40	363		1,089	59
60	Ceiling grid	2009	3,431	86	40	86		258	60
61	Roof project	2009	1,053	26	40	26		78	61
62	Lighting System	2011	28,884	722	40	722		722	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,033,309	\$ 59,248		\$ 59,248	\$	\$ 2,079,764	70

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

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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	\$ 289,391	\$ 27,160	\$ 27,160	\$		\$ 170,373	71
72	Current Year Purchases	28,339	1,117	1,117			1,117	72
73	Fully Depreciated Assets	706,595						73
74								74
75	TOTALS	\$ 1,024,325	\$ 28,277	\$ 28,277	\$		\$ 171,490	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	Resident Use only	Ford bronco	1990	\$ 3,313	\$	\$	\$		\$ 3,313	76
77	Resident Use only	Colt Wagon	1989	9,359					9,359	77
78	Resident Use only	Dodge Van	1999	35,748					35,748	78
79										79
80	TOTALS			\$ 48,420	\$	\$	\$		\$ 48,420	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)	\$ 4,106,054	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,525	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,525	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)	\$ 2,299,674	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

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

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

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

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

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

YES  NO

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

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

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

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

Facility Name & ID Number **Stephenson Nursing Center**

# **0004259**

Report Period Beginning: **12/1/10**

Ending: **11/30/11**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

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

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 141,517	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,186,040		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	755		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Property Tax Rec.</b>	500,000		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,828,312	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,033,310		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,072,744		16
17	Accumulated Depreciation (book methods)	(3,005,152)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	55,727		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,156,629	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,984,941	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 251,051	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	200,474		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	500,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Due to other funds</b>	100,000		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,051,525	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,051,525	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,933,416	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,984,941	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,666,722</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,666,722</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>266,694</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>266,694</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,933,416</b>	<b>24</b> *

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



Facility Name & ID Number Stephenson Nursing Center# 0004259Report Period Beginning: 12/1/10Ending: 11/30/11

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,298,721	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,298,721	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,293	13
14	Non-Patient Meals	5,987	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,280	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,090	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,090	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Real estate taxes</u>	513,917	28
28a	<u>Bequests/Miscellaneous</u>	125,086	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 639,003	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,947,094	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,447,399	31
32	Health Care	3,016,242	32
33	General Administration	980,585	33
<b>B. Capital Expense</b>			
34	Ownership	87,525	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	148,649	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,680,400	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	266,694	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 266,694	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 **Stephenson Nursing Center**  
 XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
 (This schedule must cover the entire reporting period.)

# 0004259

Report Period Beginning:

12/1/10

Ending:

11/30/11

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,968	2,080	\$ 65,011	\$ 31.26	1
2	Assistant Director of Nursing	1,904	2,080	54,288	26.10	2
3	Registered Nurses	18,824	21,793	508,647	23.34	3
4	Licensed Practical Nurses	19,604	20,931	347,369	16.60	4
5	CNAs & Orderlies	96,381	102,943	1,186,909	11.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,080	33,000	15.87	9
10	Activity Assistants	8,530	9,186	86,279	9.39	10
11	Social Service Workers	4,714	4,987	70,831	14.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,030	6,377	95,057	14.91	17
18	Housekeepers	15,028	15,873	146,808	9.25	18
19	Laundry	13,193	14,062	110,182	7.84	19
20	Administrator	2,024	2,080	72,377	34.80	20
21	Assistant Administrator					21
22	Other Administrative	3,888	4,160	62,369	14.99	22
23	Office Manager	2,128	2,200	39,597	18.00	23
24	Clerical	6,781	741	99,276	133.98	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	1,624	1,872	25,656	13.71	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Purchasing</u>	1,889	1,938	18,525	9.56	33
34	TOTAL (lines 1 - 33)	206,470	215,383	\$ 3,022,181 *	\$ 14.03	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		\$ 723,458		35
36	Medical Director		6,000		36
37	Medical Records Consultant		1,170		37
38	Nurse Consultant		0		38
39	Pharmacist Consultant		7,799		39
40	Physical Therapy Consultant		see other		40
41	Occupational Therapy Consultant		see other		41
42	Respiratory Therapy Consultant		0		42
43	Speech Therapy Consultant		see other		43
44	Activity Consultant		0		44
45	Social Service Consultant		4,272		45
46	Other(specify)				46
47	<u>Psychiatric consultant</u>		16,718		47
48	<u>Infinity Rehab</u>		350,275		48
49	TOTAL (lines 35 - 48)		\$ 1,109,692		49

C. CONTRACT NURSES

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

Facility Name & ID Number **Stephenson Nursing Center**

# **0004259**

Report Period Beginning: **12/1/10**

Ending: **11/30/11**

**XIX. SUPPORT SCHEDULES**

<b>A. Administrative Salaries</b>				<b>D. Employee Benefits and Payroll Taxes</b>			<b>F. Dues, Fees, Subscriptions and Promotions</b>	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Darnell Fortney	Administrator	0	\$ 72,377	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
Chris Schneirla	Marketing Dir	0	30,506	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
Stacy Cain	Scheduler	0	23,115	FICA Taxes		Health Care Worker Background Check		
RaeAnn Miller	Human Resources	0	31,863	Employee Health Insurance		(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	85 1,360	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and subscriptions	569	
						Marketing	4,842	
						Advertising and publishing	5,402	
						Licenses	4,208	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 157,861			Non-allowable advertising	( )	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount			\$ 16,381		
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$	
(Attach a copy of any management service agreement)								
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Freeport Joranal Standard	Legal Notice Publication		\$ 37			\$	Out-of-State Travel	\$
FR&R Healthcare	Medicare Report		4,250					
Wipfli LLP	State Cost Report		2,500				In-State Travel	693
							Seminar Expense	1,687
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,787				\$ 2,380	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Stephenson Nursing Center

# 0004259

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. IL Nursing Home Assn \$100
- (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? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,745 Line 10-2
- (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. n/a
- (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. \$ 35,480  
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? n/a
- (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. \$ 11,447 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? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ no  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? \_\_\_\_\_**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ no**
- (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? n/a  
Attach invoices and a summary of services for all architect and appraisal fees.