

Facility Name & ID Number Collins Square

0048009 Report Period Beginning: 4/1/2012 Ending: 3/31/13

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,666			5,666	13
14	TOTALS	5,666			5,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.02%

D. How many bed-hold days during this year were paid by the Department?

21 (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 Non-allowable costs have been eliminated in Schedule V, Column 7

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 04/01/06

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/01/06 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 3/31/13 Fiscal Year: 3/31/13

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

Facility Name & ID Number

Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	39,304	4,974	1,292	45,570		45,570	45,570			1
2	Food Purchase		41,990		41,990		41,990	41,990			2
3	Housekeeping	23,116	4,047		27,163		27,163	27,163			3
4	Laundry		2,995		2,995		2,995	2,995			4
5	Heat and Other Utilities			10,553	10,553		10,553	10,553			5
6	Maintenance	7,706	8,769	3,821	20,296		20,296	20,296			6
7	Other (specify):*										7
8	TOTAL General Services	70,126	62,775	15,666	148,567		148,567	148,567			8
	B. Health Care and Programs										
9	Medical Director			3,840	3,840		3,840	3,840			9
10	Nursing and Medical Records	168,519	6,039	2,323	176,881		176,881	176,881			10
10a	Therapy										10a
11	Activities		656	320	976		976	976			11
12	Social Services										12
13	CNA Training	9,955			9,955		9,955	9,955			13
14	Program Transportation			3,624	3,624		3,624	3,624			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	178,474	6,695	10,107	195,276		195,276	195,276			16
	C. General Administration										
17	Administrative	11,774			11,774		11,774	11,774			17
18	Directors Fees										18
19	Professional Services			69,426	69,426		69,426	(53)	69,373		19
20	Dues, Fees, Subscriptions & Promotions			5,011	5,011		5,011	15	5,026		20
21	Clerical & General Office Expenses	18,211	2,289	4,503	25,003		25,003	2	25,005		21
22	Employee Benefits & Payroll Taxes			63,919	63,919		63,919		63,919		22
23	Inservice Training & Education			4,582	4,582		4,582		4,582		23
24	Travel and Seminar			112	112		112		112		24
25	Other Admin. Staff Transportation			1,464	1,464		1,464		1,464		25
26	Insurance-Prop.Liab.Malpractice			5,834	5,834		5,834		5,834		26
27	Other (specify):*										27
28	TOTAL General Administration	29,985	2,289	154,851	187,125		187,125	(36)	187,089		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	278,585	71,759	180,624	530,968		530,968	(36)	530,932		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 Collins Square

#0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			39,987	39,987	39,987	(423)	39,564				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			39,987	39,987	39,987	(423)	39,564				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,003	42,003	42,003		42,003				42
43	Other (specify):* Non-allowable Costs			535	535	535	(535)					43
44	TOTAL Special Cost Centers			42,538	42,538	42,538	(535)	42,003				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	278,585	71,759	263,149	613,493	613,493	(994)	612,499				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 Collins Square

0048009

Report Period Beginning: 4/1/2012

Ending: 3/31/13

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(423)	30		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	(297)	43		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	(53)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(128)	43		24
25	Fund Raising, Advertising and Promotional	(110)	43		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,011)		\$	30

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	2	
		Amount	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)	17		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 17		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (994)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Collins Square

ID# 0048009

Report Period Beginning: 4/1/2012

Ending: 3/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Collins Square# 0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	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	(53)	0	0	0	0	0	0	0	0	0	0	(53)	19
20	Fees, Subscriptions & Promotions	0	15	0	0	0	0	0	0	0	0	0	15	20
21	Clerical & General Office Expenses	0	2	0	0	0	0	0	0	0	0	0	2	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	(53)	17	0	0	0	0	0	0	0	0	0	(36)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53)	17	0	0	0	0	0	0	0	0	0	(36)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Collins Square# 0048009

Report Period Beginning:

4/1/2012 Ending:

3/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(423)	0	0	0	0	0	0	0	0	0	0	(423)	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	(423)	0	0	0	0	0	0	0	0	0	0	(423)	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):*	(535)	0	0	0	0	0	0	0	0	0	0	(535)	43
44	TOTAL Special Cost Centers	(535)	0	0	0	0	0	0	0	0	0	0	(535)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,011)	17	0	0	0	0	0	0	0	0	0	(994)	45

Facility Name & ID Number Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

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
None	N/A	Frances House, Inc. (FH)		See Attached Schedule I		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Concepts Plus, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)				
		See Attached Schedule I for specific homes				

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		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)		
		Item								
1	V	20	Dues, Fees & Subscriptions		Frances House, Inc.	0.00%	\$ 15	\$ 15	1	
2	V	21	Clerical & General Office Exp		Frances House, Inc.	0.00%	2	2	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			\$			\$ 17	\$ *	17	14

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

Facility Name & ID Number

Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Collins Square # 0048009 Report Period Beginning: 4/1/2012 Ending: 3/31/13

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	See Attached Schedule II								\$ 0	L18, C7	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 Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending: 3/31/13

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

Name of Related Organization Frances House, Inc.
 Street Address 285 S. Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

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

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	20	Dues, Fees & Subscriptions	Bed Days Available	5,664	30	445	192	\$ 15	1
2	21	Clerical & General Office Exp	Bed Days Available	5,664	30	46	192	2	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 491	\$		\$ 17	25

Facility Name & ID Number

Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

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

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

1. Real Estate Tax accrual used on 2012 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.)			2012	\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2013 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:	2008	<u>N/A</u>	8		
	2009	<u>N/A</u>	9		
	2010	<u>N/A</u>	10		
	2011	<u>N/A</u>	11		
	2012	<u>N/A</u>	12		
The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2012	\$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Collins Square COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0048009

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 2012 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 2012.

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

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Collins Square

0048009 Report Period Beginning:

4/1/2012 Ending:

3/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,900 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

1. Total Amount Incurred: _____ 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>Facility</u>	<u>49,200</u>	<u>2006</u>	<u>\$ 22,692</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	49,200		\$ 22,692	3

Facility Name & ID Number Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

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	16	2006	1986	\$ 194,700	\$ 14,336	14	\$ 13,913	\$ (423)	\$ 97,387
5									
6						See Att Sche V			
7									
8									
Improvement Type**									
9	Landscaping		1998	1,940	243	8	243		1,698
10						See Att Sche V			
11	Furnace		2008	6,850	457	15	457		2,322
12	Replaced Air Compressor and Dram Piping		2008	5,331	356	15	356		1,630
13	Shower		2008	3,357	479	7	479		2,317
14	Carpet		2008	17,156	3,431	5	3,431		16,584
15	Furnace		2008	6,858	457	15	457		2,286
16	Repair and Paint Ceiling		2009	14,903	2,129	7	2,129		8,693
17	Sprinkler Heads		2009	4,852	194	25	194		728
18	Wood Doors		2010	9,209	614	15	614		1,842
19	Carpet		2011	16,533	3,306	5	3,306		4,959
20	Corner Guards/Wall Guard/End Caps		2011	7,330	733	10	733		1,466
21	Bathroom #1-Drywall/Paint/Mirrors/Ceiling Vent, Light Combo/Tile		2012	14,101	1,175	12	1,175		1,175
22	Bathroom #2-Drywall/Paint/Mirrors/Ceiling Vent, Light Combo/Tile		2012	14,326	1,194	12	1,194		1,194
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	317,446	\$	29,104	\$	28,681	\$	(423)	\$	144,281	70

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

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	\$ 35,389	\$ 2,077	\$ 2,077	\$	1-15 yrs	\$ 15,745	71
72	Current Year Purchases						See Att Sche V	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 35,389	\$ 2,077	\$ 2,077	\$		\$ 15,745	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	Patient Care	2009 Ford E350 Van Terra	2009	\$ 46,965	\$ 8,806	\$ 8,806	\$	4	\$ 46,965	76
77										77
78										78
79										79
80	TOTALS			\$ 46,965	\$ 8,806	\$ 8,806	\$		\$ 46,965	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)	\$ 422,492	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,987	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,564	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (423)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 206,991	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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 Collins Square

0048009

Report Period Beginning: 4/1/2012

Ending: 3/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A Facility Owned

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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 _____.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ N/A 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	<u>N/A</u>				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 Collins Square # 0048009 Report Period Beginning: 4/1/2012 Ending: 3/31/13
 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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>138</u></p>	<p>3. CLINICAL PORTION:</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)		9,955		9,955
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 9,955	\$	\$ 9,955
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,955		

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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

- (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	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
							5	5				
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 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			\$		\$	\$			\$		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 Collins Square# 0048009Report Period Beginning: 4/1/2012

Ending:

3/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 308,484	\$ 308,484	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	271,807	271,807	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,663	8,663	6
7	Other Prepaid Expenses	10,605	10,605	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 599,559	\$ 599,559	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	22,692	13
14	Buildings, at Historical Cost	323,440	317,446	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	82,354	82,354	16
17	Accumulated Depreciation (book methods)	(209,952)	(206,991)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 205,842	\$ 215,501	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 805,401	\$ 815,060	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 45,665	\$ 45,665	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,227	21,227	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,439	2,439	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	<u>Accrued Health Liability</u>	2,104	2,104	36
37	<u>Interdivision Payable</u>	547,761	547,761	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 619,196	\$ 619,196	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 619,196	\$ 619,196	46
47	TOTAL EQUITY(page 18, line 24)	\$ 186,205	\$ 195,864	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 805,401	\$ 815,060	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 60,224	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 60,224	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	125,981	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)	\$ 125,981	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)	\$ 186,205	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Collins Square# 0048009Report Period Beginning: 4/1/2012Ending: 3/31/13

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		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 729,519		1
2	Discounts and Allowances for all Levels			2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 729,519		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	9,955		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)	\$ 9,955		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)	\$ 739,474		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	148,567		31
32	Health Care	195,276		32
33	General Administration	187,125		33
B. Capital Expense				
34	Ownership	39,987		34
C. Ancillary Expense				
35	Special Cost Centers	535		35
36	Provider Participation Fee	42,003		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 613,493		40
41	Income before Income Taxes (line 30 minus line 40)**	125,981		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 125,981		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 607,433	44
45	Private Pay - Net Inpatient Revenue	122,086	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 729,519	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	560	10,535	18.19	4
5	CNAs & Orderlies	12,687	140,368	10.29	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	3,527	39,304	10.68	15
16	Dishwashers				16
17	Maintenance Workers	482	7,706	15.24	17
18	Housekeepers	1,947	23,116	10.57	18
19	Laundry				19
20	Administrator	436	11,774	25.22	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,375	18,211	12.50	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,647	27,571	15.83	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)	22,661	\$ 278,585 *	\$ 11.48	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	Monthly \$ 1,292	L1, C3	35
36	Medical Director	Monthly 3,840	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly 100	L10, C3	38
39	Pharmacist Consultant	Monthly 220	L10, C3	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) Dental	Monthly 1,053	L10, C3	46
47	Psychological Consultant	Monthly 950	L10, C3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 7,455		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Allsopp	Administrator	None	\$ 5,583	Workers' Compensation Insurance	\$ 8,208	IDPH License Fee	\$	
Debora Leaver	Administrator	None	6,191	Unemployment Compensation Insurance		Advertising: Employee Recruitment	3,409	
				FICA Taxes	21,874	Health Care Worker Background Check		
				Employee Health Insurance	28,379	(Indicate # of checks performed <u>23</u>)	226	
				Employee Meals	1,271	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				401k	3,504	Subscriptions	834	
				Other Employee Benefits	683	IHCA Dues	542	
						Indirect costs	15	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 11,774					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 63,919	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,026	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
N/A			\$	N/A		\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				In-State Travel	
C. Professional Services							Seminar Expense	112
Vendor/Payee	Type		Amount					
RFMS, Inc.	Administrative Services		\$ 33,990				Entertainment Expense	()
LTC Support Services, LLC	Support Services		30,740				(agree to Sch. V, line 24, col. 8)	
McGladrey LLP	Accounting Services		4,643				TOTAL	\$ 112
Polsinelli Shughart PC	Legal Services-disallowed		53					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 69,426	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Collins Square

0048009

Report Period Beginning:

4/1/2012

Ending:

3/31/13

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. 542 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA Dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (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. \$ 2,011 Line 10
- (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. \$ 42,003
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. \$ 1,271 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	39,304	4,974	1,292	45,570	0	45,570	0	45,570
2. Food Purchase	0	41,990	0	41,990	0	41,990	0	41,990
3. Housekeeping	23,116	4,047	0	27,163	0	27,163	0	27,163
4. Laundry	0	2,995	0	2,995	0	2,995	0	2,995
5. Heat and Other Utilities	0	0	10,553	10,553	0	10,553	0	10,553
6. Maintenance	7,706	8,769	3,821	20,296	0	20,296	0	20,296
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	70,126	62,775	15,666	148,567	0	148,567	0	148,567
9. Medical Director	0	0	3,840	3,840	0	3,840	0	3,840
10. Nursing & Medical Records	168,519	6,039	2,323	176,881	0	176,881	0	176,881
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	0	656	320	976	0	976	0	976
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	9,955	0	0	9,955	0	9,955	0	9,955
14. Program Transportation	0	0	3,624	3,624	0	3,624	0	3,624
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	178,474	6,695	10,107	195,276	0	195,276	0	195,276
17. Administrative	11,774	0	0	11,774	0	11,774	0	11,774
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	69,426	69,426	0	69,426	-53	69,373
20. Fees, Subscriptions & Promotion	0	0	5,011	5,011	0	5,011	15	5,026
21. Clerical & General Office	18,211	2,289	4,503	25,003	0	25,003	2	25,005
22. Employee Benefits & Payroll	0	0	63,919	63,919	0	63,919	0	63,919
23. Inservice Training & Education	0	0	4,582	4,582	0	4,582	0	4,582
24. Travel and Seminar	0	0	112	112	0	112	0	112
25. Other Admin. Staff Trans	0	0	1,464	1,464	0	1,464	0	1,464
26. Insurance-Prop.Liab.Malpractice	0	0	5,834	5,834	0	5,834	0	5,834
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	29,985	2,289	154,851	187,125	0	187,125	-36	187,089
29. Total General Administrative	278,585	71,759	180,624	530,968	0	530,968	-36	530,932
30. Depreciation	0	0	39,987	39,987	0	39,987	-423	39,564
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	39,987	39,987	0	39,987	-423	39,564
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	42,003	42,003	0	42,003	0	42,003
43. Other (specify):*	0	0	535	535	0	535	-535	0
44. Total Special Cost Ce	0	0	42,538	42,538	0	42,538	-535	42,003
45. Grand Total	278,585	71,759	263,149	613,493	0	613,493	-994	612,499

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	308,484	308,484
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	271,807	271,807
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	8,663	8,663
7. Other Prepaid Expenses	10,605	10,605
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	599,559	599,559
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	10,000	22,692
14. Buildings, at Historical Cost	323,440	317,446
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	82,354	82,354
17. Accumulated Depreciation (book methods)	-209,952	-206,991
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	205,842	215,501
25. Total Assets	805,401	815,060
CURRENT LIABILITIES		
26. Accounts Payable	45,665	45,665
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	21,227	21,227
31. Accrued Taxes Payable	2,439	2,439
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,104	2,104

37. Other Current Liabilities (specify):	547,761	547,761
38. Total Current Liabilities	619,196	619,196
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	619,196	619,196
47.Total Equity	186,205	195,864
48.Total Liabilities and Equity	805,401	815,060

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	729,519
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	729,519
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	9,955
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	9,955
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	739,474
31. General Services	148,567
32. Health Care	195,276
33. General Administration	187,125
34. Ownership	39,987

35. Special Cost Centers	535
35. Provider Participation Fee	42,003
37. Other	0
40. Total Expenses	613,493
41. Income Before Income Taxes	125,981
42. Income Taxes	0
43. Net Income or Loss for the Year	125,981