

		FOR BHF USE					

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**2013**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2013)**

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>0036285</u></p> <p><b>Facility Name:</b> <u>Richland Manor</u></p> <p><b>Address:</b> <u>1066 W Main, Box 10</u> <u>Olney</u> <u>62450</u>                                                        Number                                                City                                                Zip Code</p> <p><b>County:</b> <u>Richland</u></p> <p><b>Telephone Number:</b> <u>(618)395-2437</u>      <b>Fax #</b> <u>(618)392-2673</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>09/15/90</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code <u>501 c 3</u> </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Rita Armbrust</u>      <b>Telephone Number:</b> <u>618-548-0309</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 c 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><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>10/01/12</u> to <u>09/30/13</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Terry Elwood</u>            (Title) <u>President</u> </td> </tr> <tr> <td style="width: 30%; padding: 5px; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>(     )</u>      Fax # (     )         </td> </tr> </table> <p style="text-align: center; margin-top: 10px;"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>        201 S. Grand Avenue East        Springfield, IL 62763-0001      Phone # (217) 782-1630     </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Terry Elwood</u> (Title) <u>President</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>(     )</u> Fax # (     )
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 c 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Terry Elwood</u> (Title) <u>President</u>							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>(     )</u> Fax # (     )							

Facility Name & ID Number Richland Manor

# 0036285 Report Period Beginning: 10/01/12 Ending: 09/30/13

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 \_\_\_\_\_

	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,538			5,538
14	TOTALS	5,538			5,538

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.83%

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

14 (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)

N/A

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 9/15/90

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

YES  Date 7/13/91 NO

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

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

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

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/13 Fiscal Year: 09/30/13

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

Facility Name &amp; ID Number

Richland Manor

# 0036285

Report Period Beginning:

10/01/12

Ending:

09/30/13

**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
	<b>A. General Services</b>										
1	Dietary	39,892	3,823	3,421	47,136		47,136		47,136		1
2	Food Purchase		40,018		40,018	(1,778)	38,240	73	38,313		2
3	Housekeeping	16,963	5,980		22,943		22,943	122	23,065		3
4	Laundry		3,988		3,988		3,988		3,988		4
5	Heat and Other Utilities			10,141	10,141		10,141	1,665	11,806		5
6	Maintenance		2,392	5,700	8,092		8,092	95	8,187		6
7	Other (specify):* <b>Garbage P-U</b>			1,801	1,801		1,801	12	1,813		7
8	<b>TOTAL General Services</b>	56,855	56,201	21,063	134,119	(1,778)	132,341	1,967	134,308		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	168,515	8,375	6,844	183,734	(6,761)	176,973		176,973		10
10a	Therapy										10a
11	Activities	18,918	52	290	19,260		19,260		19,260		11
12	Social Services	10,021			10,021		10,021		10,021		12
13	CNA Training										13
14	Program Transportation			5,612	5,612	(905)	4,707		4,707		14
15	Other (specify):* <b>Hab Aide Training</b>					6,761	6,761		6,761		15
16	<b>TOTAL Health Care and Programs</b>	197,454	8,427	12,746	218,627	(905)	217,722		217,722		16
	<b>C. General Administration</b>										
17	Administrative	77,260			77,260	(500)	76,760	15,000	91,760		17
18	Directors Fees							1,275	1,275		18
19	Professional Services			91,200	91,200		91,200	1,535	92,735		19
20	Dues, Fees, Subscriptions & Promotions			1,093	1,093		1,093	388	1,481		20
21	Clerical & General Office Expenses	69,136	7,453		76,589		76,589	4,728	81,317		21
22	Employee Benefits & Payroll Taxes			31,303	31,303	1,778	33,081	11,049	44,130		22
23	Inservice Training & Education			48	48	500	548		548		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			814	814	684	1,498	3,862	5,360		25
26	Insurance-Prop.Liab.Malpractice			100	100		100	6,676	6,776		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	146,396	7,453	124,558	278,407	2,462	280,869	44,513	325,382		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	400,705	72,081	158,367	631,153	(221)	630,932	46,480	677,412		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 &amp; ID Number

Richland Manor

#0036285

Report Period Beginning:

10/01/12

Ending:

09/30/13

## 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	
	<b>D. Ownership</b>											
30	Depreciation			19,662	19,662		19,662	875	20,537			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,200	4,200			34
35	Rent-Equipment & Vehicles							2,400	2,400			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			19,662	19,662		19,662	7,475	27,137			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					221	221		221			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,702	36,702		36,702		36,702			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			36,702	36,702	221	36,923		36,923			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	400,705	72,081	214,731	687,517		687,517	53,955	741,472			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 Richland Manor

# 0036285

Report Period Beginning: 10/01/12

Ending: 09/30/13

**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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	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)	53,955	Pg 6a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 53,955		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 53,955		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		\$ 221	L14	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 221		47

BHF USE ONLY						
48		49		50		51
						52

Richland Manor

ID# 0036285

Report Period Beginning: 10/01/12

Ending: 09/30/13

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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Richland Manor# 0036285

Report Period Beginning:

10/01/12

Ending:

09/30/13

## 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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<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>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29



STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

# 0036285

Report Period Beginning:

10/01/12 Ending:

Summary B

09/30/13

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)	
	<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>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</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>45</b>

**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
		Prairie Estates	Flora	(Marion County Horizon Center)	Salem	Home Office

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	See attached 6a	\$ 53,955	Marion County Horizon Center	0.00%	\$ 107,910	\$ 53,955	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ 53,955			\$ 107,910	\$ * 53,955	14

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

Facility Name & ID Number

Richland Manor

# 0036285

Report Period Beginning:

10/01/12

Ending:

09/30/13

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 Richland Manor # 0036285 Report Period Beginning: 10/01/12 Ending: 09/30/13

## 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	Terry Elwood	Director	Board Member	0.00	825	2	6.00	Director Fee	\$ 825	L18,C7	1
2	Amanda Miller	Director	Board Member	0.00	225	1	3.00	Director Fee	225	L18,C7	2
3	Julie Quinn	Director	Board Member	0.00	225	1	3.00	Director Fee	225	L18,C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,275		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 Richland Manor

# 0036285

Report Period Beginning:

10/01/12

Ending: 09/30/13

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 Marion County Horizon Center  
 Street Address 122 N Hotze Rd  
 City / State / Zip Code Salem, IL 62881  
 Phone Number ( 618 548-0309  
 Fax Number ( 618 548-3720

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	2	Food	2	2	\$ 146	\$ 0	1	\$ 73	1
2	3	Housekeeping Supplies	2	2	243	0	1	122	2
3	5	Utilities	2	2	3,330	0	1	1,665	3
4	6	Maintenance Supplies	2	2	4	0	1	2	4
5	6	Maintenance Repairs	2	2	186	0	1	93	5
6	7	Garbage P-U	2	2	24	0	1	12	6
7	17	Management Fees	2	2	30,000	0	1	15,000	7
8	18	Director Fees	2	2	2,550	0	1	1,275	8
9	19	Accounting Fees	2	2	3,070	0	1	1,535	9
10	20	License Fees	2	2	10	0	1	5	10
11	20	Dues & Subscriptions	2	2	766	0	1	383	11
12	21	Telephone	2	2	3,666	0	1	1,833	12
13	21	Office Supplies	2	2	1,791	0	1	896	13
14	21	Computer Expense	2	2	3,998	0	1	1,999	14
15	22	W/C Insurance	2	2	22,097	0	1	11,049	15
16	25	Gas & Oil	2	2	4,678	0	1	2,339	16
17	25	Trans. Rep & Main	2	2	3,046	0	1	1,523	17
18	26	Building Insurance	2	2	13,352	0	1	6,676	18
19	30	Depreciation	2	2	1,750	0	1	875	19
20	34	Office Rent	2	2	8,400	0	1	4,200	20
21	35	Vehicle Rent	2	2	4,800	0	1	2,400	21
22									22
23									23
24									24
25	TOTALS				\$ 107,907	\$		\$ 53,955	25

Facility Name & ID Number

Richland Manor

# 0036285

Report Period Beginning:

10/01/12

Ending:

09/30/13

**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	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			
	<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>						\$ None	\$ None			\$ None	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$ None                             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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 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 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. <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.		\$	None		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	None	8		
	2009	None	9		
	2010	None	10		
	2011	None	11		
	2012	None	12		
				<b>FOR BHF USE ONLY</b>	
				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 Richland Manor COUNTY Richland  
 FACILITY IDPH LICENSE NUMBER 0036285  
 CONTACT PERSON REGARDING THIS REPORT Rita Armbrust  
 TELEPHONE 618 548-0309 FAX #: 618 548-3720

**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.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		<b>TOTALS</b>	\$ <u>None</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       x   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 Richland Manor

# 0036285 Report Period Beginning:

10/01/12 Ending:

09/30/13

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 4,572 B. General Construction Type: Exterior Vinyl Frame Wood & Brick Number of Stories One

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

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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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>25,425</u>	<u>1991</u>	<u>\$ 9,000</u>	1
2					2
3	<b>TOTALS</b>	<b>25,425</b>		<b>\$ 9,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1991	1985	\$ 347,410	\$ 13,896	25	\$ 13,896	\$	\$ 308,032	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Storage Shed		1987	869		15			869	9
10	Remodeling		1990	4,872	195	25	195		4,435	10
11	Storage Shed		1991	618		20			618	11
12	Wood Deck		1991	2,978		15			2,978	12
13	Paving/Concrete		1991	11,475		20			11,475	13
14	Lawn		1991	768		10			768	14
15	Landscaping		1991	740		10			740	15
16	Air Conditioning System		1994	1,500		15			1,500	16
17	Door, cabinets, countertop		1995	1,767		10			1,767	17
18	Driveway Work, Concrete		1997	5,280	264	20	264		4,334	18
19	Air Conditioning System (4-ton)		1997	1,242		5			1,242	19
20	Carpet/Installation		1999	9,217		10			9,217	20
21	Cabinets/Installation		1999	8,195		10			8,195	21
22	Garage (Van/Storage)		2000	22,718	1,136	20	1,136		15,241	22
23	Fence		2000	5,248	350	15	350		4,608	23
24	Concrete Driveway		2000	4,439	222	20	222		2,960	24
25	Garage Shelving		2000	1,176		10			1,176	25
26	Landscaping		2001	600		10			600	26
27	Air Conditioning/Heating System		2001	3,400		10			3,400	27
28	Bathroom Floor Replaced		2005	2,048	102	20	102		893	28
29	Roof and Guttering		2009	17,287	576	30	576		2,518	29
30	Handicapped Tub and Shower in 2 Bathrooms		2010	12,240	1,224	10	1,224		4,474	30
31	Wheelchair Ramp		2010	2,445	163	15	163		489	31
32	Fire Alarm System		2011	3,167	317	10	317		792	32
33	Air conditioning		2012	2,200	147	15	147		147	33
34										34
35										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 & ID Number Richland Manor

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)	\$ 473,899	\$ 18,592		\$ 18,592	\$	\$ 393,468	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	\$ 70,823	\$ 821	\$ 821	\$	10	\$ 70,396	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Equipment	519	74	74		7	231	74
75	TOTALS	\$ 71,342	\$ 895	\$ 895	\$		\$ 70,627	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	Facility Transportation	Dodge Caravan 2005	3/22/2005	\$ 20,423	\$	\$	\$	5	\$ 20,423	76
77	Facility Transportation	GMC Envoy 2	12/10/2010	5,250	1,050	1,050		5	2,975	77
78										78
79										79
80	TOTALS			\$ 25,673	\$ 1,050	\$ 1,050	\$		\$ 23,398	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 579,914	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,537	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,537	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)	\$ 487,493	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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	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: Shivam Hotels, LLC

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	Office	1987		3/9/92	4,200			5
6								6
7	TOTAL				\$ 4,200			7

10. Effective dates of current rental agreement:

Beginning 03/09/2009

Ending 03/09/2014

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

Fiscal Year Ending                      Annual Rent

12. 09/30/2014                      \$ 4,200

13. Month by Month                      \$ 4,200

14. Month by Month                      \$ 4,200

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

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	Facility Transportation	2010 GMC Terrain	\$ 200.00	\$ 2,400	17
18					18
19					19
20					20
21	TOTAL		\$ 200.00	\$ 2,400	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 Richland Manor # 0036285 Report Period Beginning: 10/01/12 Ending: 09/30/13  
 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>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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		55		55
3	Classroom Wages (a)		1,894		1,894
4	Clinical Wages (b)		3,788		3,788
5	In-House Trainer Wages (c)		1,024		1,024
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,761	\$	\$ 6,761
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,761		

- (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.

**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**

<b>COMPLETED</b>	
1. From this facility	5
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>5</b>

- (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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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>			\$ Non	None	\$ None	\$ None	None	\$ None	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 Richland Manor# 0036285Report Period Beginning: 10/01/12Ending: 09/30/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/13

(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	\$ 274,056	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	71,680		3
4	Supply Inventory (priced at <u>COST</u> )	5,070		4
5	Short-Term Investments			5
6	Prepaid Insurance	83		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 350,889	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000		13
14	Buildings, at Historical Cost	391,103		14
15	Leasehold Improvements, at Historical Cost	82,794		15
16	Equipment, at Historical Cost	91,246		16
17	Accumulated Depreciation (book methods)	(483,114)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 91,029	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 441,918	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 7,347	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,683		30
31	Accrued Taxes Payable (excluding real estate taxes)	817		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	6,378		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 25,225	\$	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>	\$ 25,225	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 416,693	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 441,918	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>490,279</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>490,279</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(73,586)	<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>(73,586)</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>416,693</b>	<b>24</b> *

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

**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	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 606,569	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 606,569	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	6,761	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	221	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,982	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	380	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 380	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 613,931	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	134,119	31
32	Health Care	218,627	32
33	General Administration	278,407	33
<b>B. Capital Expense</b>			
34	Ownership	19,662	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	36,702	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 687,517	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(73,586)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (73,586)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 606,569	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	None	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 606,569	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 Richland Manor

# 0036285

Report Period Beginning:

10/01/12

Ending:

09/30/13

**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	170	4,029	23.70	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,154	9,741	8.44	9
10	Activity Assistants	872	9,177	10.52	10
11	Social Service Workers	400	10,021	25.05	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	610	7,726	12.67	14
15	Cook Helpers/Assistants	3,099	32,166	10.33	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,702	16,963	9.97	18
19	Laundry				19
20	Administrator	1,120	34,344	28.62	20
21	Assistant Administrator	1,680	42,916	24.95	21
22	Other Administrative				22
23	Office Manager	2,000	48,261	23.20	23
24	Clerical	840	20,875	23.72	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	280	4,227	13.21	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	15,874	160,259	9.72	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>H.A.T. Trainer</u>				33
34	TOTAL (lines 1 - 33)	29,801	30,710	\$ 400,705 *	\$ 13.05 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	70	\$ 3,421	L1, C3 35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	12	1,003	L10, C3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	5	242	L10, C3 43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>Physician Consultant</u>	40	3,300	L10, C3 47
48	<u>Psychologist Consultant</u>	17	1,575	L10, C3 48
49	TOTAL (lines 35 - 48)	144	\$ 9,541	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)	None	\$ None	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	
Trena Briscoe, LNHA	LNHA	0	\$ 34,344	Workers' Compensation Insurance	\$ 11,049	IDPH License Fee	\$	
Libby Riggs, LNHA	Asst. Admn.	0	42,916	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	359	
				FICA Taxes	30,769	Health Care Worker Background Check		
				Employee Health Insurance	0	(Indicate # of checks performed <u>7</u> )	250	
				Employee Meals	1,778	Patient Background Checks	30	
				Illinois Municipal Retirement Fund (IMRF)*		Due/Subscriptions	539	
				Staff TB Test	10	Licenses	303	
				Staff Flu Vaccine	264			
				Christmas Gift Cards for Staff	260			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 77,260			Non-allowable advertising	( )	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 44,130	\$ 1,481		
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
<b>C. Professional Services</b>							Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Health Care Mgmt. Corp.	Admn. Consulting Fees		\$ 91,200					
							In-State Travel	
							Seminar Expense	
							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.)			\$ 91,200	\$ None			\$ None	

\* 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	None	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Richland Manor

# 0036285

Report Period Beginning:

10/01/12

Ending:

09/30/13

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? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 0
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,657 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. \_\_\_\_\_
- (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. \$ 36,702  
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. \$ 1,778 Has any meal income been offset against related costs? N/A 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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 221
  - c. What percent of all travel expense relates to transportation of nurses and patients? 46.8%
  - 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? No  
Firm Name: \_\_\_\_\_
- (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.

1 Employee Benefits and Payroll Taxes, Line 22	\$1,778	
Food Purchase, Line 2		\$1,778

To reclassify free employee meals from food costs to employee benefits

2 Medically Necessary Transportation, Line 38	\$221	
Program Transportation, Line 14		\$221

To reclassify medical transportation for clients per the separate DPA contract

3 Inservice Training & Education, Line 23	\$500	
Administrative, Line 17		\$500

To re-classify in-service training paid to instructors as follows:

- 10/17/12 Libby Riggs--Infection Control
- 10/29/12 Libby Riggs--Falls/Lifting/Gait Belt Use
- 1/7/13 Libby Riggs--Confidentiality/Doct/Ben Mgmt/Act Tx
- 2/4/13 Libby Riggs--Emergency Preparedness
- 4/29/13 Libby Riggs--Fire Safety
- 6/12/13 Libby Riggs--Hot Weather Emergency
- 7/1/13 Resident Rights/Reporting Abuse & Neglect
- 8/2/13 Libby Riggs--Post-Survey/Review of IDPH Regs.
- 9/10/13 Libby Riggs--Approp Client/DSP Interactions & Reporting of Abuse
- 9/25/13 Libby Riggs--Oral Care

4 Other Admn. Staff Transportation, Line 25	\$684	
Program Transportation, Line 14		\$684

According to the facility's van mileage log, 7,985 miles were driven this fiscal year (84,593 less 76,608.)  
According to the Envoy mileage log, 2,809 miles were driven this fiscal year (105,285 less 102,476.)  
Of that, 1498 miles were for unloaded errand miles for the facility. Therefore:



Line 25 Other Admn. Travel =  $(1498 \text{ miles} / (7,985 + 2,809 \text{ miles}) \times \$4924 = \$684$

5 Habilitation Aide Training, Line 15	\$6,761	
Nursing and Medical Records, Line 10		\$6,761

To re-classify Habilitation Aide Training Expenses.

Schedule V Line Reference	Item	Total Marion County Horizon Center Expenses	% of Ownership	Allocation Prairie Estates	Richland Manor
2	Food	\$146	0%	73	73
3	Housekeeping Supplie	\$243	0%	121	122
5	Utilities	\$3,330	0%	\$1,665	\$1,665
6	Maintenance Supplies	\$4	0%	\$2	\$2
6	Repairs	\$186	0%	\$93	\$93
7	Garbage Pick-up	\$24	0%	\$12	\$12
17	Management Fees	\$30,000	0%	\$15,000	\$15,000
18	Director Fees	\$2,550	0%	\$1,275	\$1,275
19	Accounting	\$3,070	0%	\$1,535	\$1,535
20	License fees	\$10	0%	\$5	\$5
20	Dues & Subscriptions	\$766	0%	\$383	\$383
20	Employee Background Checks		0%	\$0	\$0
21	Telephone	\$3,666	0%	\$1,833	\$1,833
21	Office Supplies	\$1,791	0%	\$895	\$896
21	Computer Expense	\$3,998	0%	\$1,999	\$1,999
22	W/C Insurance	\$22,097	0%	\$11,048	\$11,049
22	Emp. Health Ins.	\$0	0%	\$0	\$0
22	State Unemp Taxes	\$0	0%	\$0	\$0
25	Gas & Oil	\$4,678	0%	\$2,339	\$2,339
25	Trans. Rep & Main.	\$3,046	0%	\$1,523	\$1,523
26	Building Insurance	\$13,352	0%	\$6,676	\$6,676
30	Depreciation	\$1,750	0%	\$875	\$875
34	Office Rent	\$8,400	0%	\$4,200	\$4,200
35	Vehicle Rent	<u>\$4,800</u>	0%	<u>\$2,400</u>	<u>\$2,400</u>
		<u>\$107,907</u>		<u>\$53,952</u>	<u>\$53,955</u>

	#0036277 Prairie <u>Estates</u>	#0036285 Richland <u>Manor</u>	<u>Total</u>
Terry Elwood	\$825	\$825	\$1,650
Amanda Miller	\$225	\$225	\$450
Julie Quinn	<u>\$225</u>	<u>\$225</u>	<u>\$450</u>
Totals	<u>\$1,275</u>	<u>\$1,275</u>	<u>\$2,550</u>

	<u>Cost</u>	Current Book <u>Dep.</u>	Straight Line <u>Dep.</u>	<u>Adj.</u>	Component <u>Life</u>	Accm <u>Dep.</u>
Equipment (Purchased in Prior Years)						
Home Office	\$28,170	\$148			7	
% Home Office Allocated		<u>x.5</u>				
	\$9,564	\$74	\$74			\$231
Richland Manor Equipment	<u>\$61,778</u>	<u>\$821</u>	<u>\$821</u>	0		<u>\$70,396</u>
Total XI-C, Line 75	<u>\$71,342</u>	<u>\$895</u>	<u>\$895</u>	<u>0</u>		<u>\$70,627</u>

**Travel and Seminar, Line 24:**

<u>Job Title</u>	<u>Date</u>	<u>Location</u>	<u>Title</u>	<u>Sponsor</u>	<u>Seminar Cost</u>	<u>Mileage Paid</u>	<u>Hotel Cost</u>	<u>Food Costs</u>	<u>Total Costs</u>
None									

**Other Admn. Transportation, Line 25**

Reimbursement to employees for administrative miles were reimbursed at a rate of \$.45/mile for the period 10/01/12 to 09/30/13. Detailed logs of these miles are maintained at the facility.

Tt miles reimbursed - 1808 miles x \$.45/mile	\$814
Less miles re-classed to Travel & Seminar	\$0
Rep/Main, gas&oil for vehicles (fm home office)	\$3,862
1,498 miles logged on van/Envoy for admin use	<u>\$684</u>
Line 25, Column 8	<u>\$5,360</u>