FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0051987

Facility Name: STUART ESTATES

Address: 13 NORTHBROOK (Number) MCLEANSBORO (City) 62859 (Zip Code)

County: HAMILTON

Telephone Number: 618-643-3566 **Fax #** 618-643-2377

HFS ID Number:

Date of Initial License for Current Owners: 09/01/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SUSAN MCCAULEY **Telephone Number:** 618-244-7701
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) TONYA D LINDSEY
(Title) PRESIDENT

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		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		5,840	6
7	16	TOTALS		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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,849			4,849	13
14	TOTALS	4,849			4,849	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.03%

D. How many bed-hold days during this year were paid by the Department?
20 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 09/01/12

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/29/12 NO [ ]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number STUART ESTATES # 0051987 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	29,457	2,065	2,200	33,722		33,722		33,722			1
2	Food Purchase		40,592		40,592		40,592		40,592			2
3	Housekeeping	14,595	3,765		18,360		18,360		18,360			3
4	Laundry	4,865	1,933		6,798		6,798		6,798			4
5	Heat and Other Utilities			18,640	18,640		18,640		18,640			5
6	Maintenance		1,517	9,800	11,317		11,317		11,317			6
7	Other (specify):*											7
8	**TOTAL General Services**	48,917	49,872	30,640	129,429		129,429		129,429			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	227,535	16,939	1,375	245,849		245,849		245,849			10
10a	Therapy			8,089	8,089		8,089		8,089			10a
11	Activities	17,093	494		17,587		17,587		17,587			11
12	Social Services			2,913	2,913		2,913		2,913			12
13	CNA Training	4,950	180		5,130		5,130		5,130			13
14	Program Transportation		5,249		5,249		5,249		5,249			14
15	Other (specify):* DENTAL/VISION/POD			4,985	4,985		4,985		4,985			15
16	**TOTAL Health Care and Programs**	249,578	22,862	19,162	291,602		291,602		291,602			16
	C. General Administration											
17	Administrative	36,102			36,102		36,102		36,102			17
18	Directors Fees			4,000	4,000		4,000		4,000			18
19	Professional Services			2,365	2,365		2,365		2,365			19
20	Dues, Fees, Subscriptions & Promotions			1,340	1,340		1,340		1,340			20
21	Clerical & General Office Expenses	22,586	10,366	4,510	37,462		37,462		37,462			21
22	Employee Benefits & Payroll Taxes			59,979	59,979		59,979		59,979			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation		5,249		5,249		5,249		5,249			25
26	Insurance-Prop.Liab.Malpractice			8,125	8,125		8,125		8,125			26
27	Other (specify):*											27
28	**TOTAL General Administration**	58,688	15,615	80,319	154,622		154,622		154,622			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	357,183	88,349	130,121	575,653		575,653		575,653			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 STUART ESTATES #0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			48,084	48,084		48,084		48,084			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,206	30,206		30,206		30,206			32
33	Real Estate Taxes			11,223	11,223		11,223		11,223			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			89,513	89,513		89,513		89,513			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			40,512	40,512		40,512		40,512			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,512	40,512		40,512		40,512			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	357,183	88,349	260,146	705,678		705,678		705,678			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 STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

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

BHF USE ONLY								
48		49		50		51		52

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

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

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

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

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

STUART ESTATES

ID# 0051987

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STUART ESTATES **#** 0051987 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STUART ESTATES **#** 0051987 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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
TONYA D LINDSEY	100%	BELLE MANOR	BELLEVILLE	COUNTRY LANE	MCLEANSBORO	CILA
		MEADOWBROOK ESTATES	MCLEANSBORO	EASTVIEW	BELLEVILLE	CILA
		SUTTON HOUSE	MOUNT VERNON	IMAGE HOUSE	MOUNT VERNON	CILA
		TRAFFORD ESTATES	FAIRFIELD	KENSINGTON	BELLEVILLE	CILA
				RICHVIEW	MOUNT VERNON	CILA
				WOODLAND ACRES	MOUNT VERNON	CILA

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	TONYA D LINDSEY	PRESIDENT	ADMINISTRATIV	1.00	66,400	8	20.00	SALARY	$ 16,600	17-1	1
2	TONYA D LINDSEY		DIRECTOR		16,000			FEE	4,000	18-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,600		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 STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	PEOPLES NAT'L BANK		X	PURCHASE OF FACILITIES	$2,798.00	08/29/125	$ 257,000	$ 242,210	12/29/22	5.0000	$ 12,837	1
2	WELLS FARGO BANK NA		X	PURCHASE OF FACILITIES	$1,034.03	01/16/13	154,200	152,596	01/01/33	3.9900	3,053	2
3	STEVE & BETH QUICK		X	PURCHASE OF FACILITIES	$428.33	02/29/12	102,800	102,800	02/29/32	5.0000	5,140	3
4	TONYA D LINDSEY	X		PURCHASE OF FACILITIES	$162.00	08/29/12	40,000	40,000	12/29/22	5.0000	2,000	4
5												5
	Working Capital											
6	PEOPLES NAT'L BANK		X	WORKING CAPITAL	$561.90	08/02/12	50,000	45,498	08/29/22	6.0000	3,209	6
7	PEOPLES NAT'L BANK		`X	LINE OF CREDIT	DEMAND	08/27/13	150,000		08/25/14	5.0000	1,670	7
8	FORD CREDIT		X	VEHICLE	$159.02	11/30/12	8,049	6,522	12/14/17	6.7900	2,297	8
9	TOTAL Facility Related				$5,143.28		$ 762,049	$ 589,626			$ 30,206	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 762,049	$ 589,626			$ 30,206	15

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

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

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.**	$ 10,805	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.)		$ 11,014	2
3. Under or (over) accrual (line 2 minus line 1).		$ 209	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 11,014	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.		$ 11,223	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	11,122	8
	2009	11,209	9
	2010	11,534	10
	2011	11,372	11
	2012	11,014	12

	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 STUART ESTATES COUNTY HAMILTON

FACILITY IDPH LICENSE NUMBER 0051987

CONTACT PERSON REGARDING THIS REPORT SUSAN MCCAULEY

TELEPHONE 618-244-7701 FAX #: 618-244-7704

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-152-014-10	S 1.6A OF BLK 15 LYING N OF	$ 11,014.26	$ 11,014.26
2.		NORTHBROOK DR & E OF	$	$
3.		L&N RR MH POWELL'S ADD	$	$
4.		DOR #91-033-0003	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 11,014.26	$ 11,014.26

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 STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,560 B. General Construction Type: Exterior BRICK Frame WOOD SPRINKLED Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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		45,000	2012	$ 45,300	1
2					2
3	TOTALS	45,000		$ 45,300	3

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		2012		$ 758,485	$ 38,730	27.5	$ 38,730	$	$ 52,234	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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 STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)		$ 758,485	$ 38,730		$ 38,730	$	$ 52,234	70

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 20,000	$ 2,856	$ 2,856	$	7	$ 3,811	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 20,000	$ 2,856	$ 2,856	$		$ 3,811	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	2003 FORD WINDSTAR	2012	$ 4,900	$ 980	$ 980	$	5	$ 1,307	76
77	PATIENT	2008 CHRYSLER LIFT	2012	15,300	3,060	3,060		5	4,080	77
78	ADMIN	2010 FORD FUSION	2012	3,540	708	708		5	944	78
79	ADMIN	2013 FORD F-150	2012	8,749	1,750	1,750		5	1,896	79
80	TOTALS			$ 32,489	$ 6,498	$ 6,498	$		$ 8,227	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)	$ 856,274	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 48,084	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 48,084	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)	$ 64,272	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	36	144		180
3	Classroom Wages (a)	330	1,320		1,650
4	Clinical Wages (b)	660	2,640		3,300
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 1,026	$ 4,104	$	$ 5,130
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,130			

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
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.

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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

STATE OF ILLINOIS

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 73,730	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	84,800		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,009		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DEPOSITS	259		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 162,798	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	45,300		13
14	Buildings, at Historical Cost	758,485		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	40,200		16
17	Accumulated Depreciation (book methods)	(64,272)		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)**	$ 779,713	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 942,511	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 10,929	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	256,332		29
30	Accrued Salaries Payable	29,091		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,630		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,704		32
33	Accrued Interest Payable	1,898		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED DAY TRAINING	20,749		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 338,333	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	194,820		39
40	Mortgage Payable	394,806		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	COMMON STOCK	100		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 589,726	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 928,059	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,452	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 942,511	$	48

***(See instructions.)**

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 102,967	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 102,967	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(88,515)	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)**	$ (88,515)	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)**	$ 14,452	24	*

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 617,163	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 617,163	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 617,163	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	129,429	31
32	Health Care	291,602	32
33	General Administration	154,622	33
	B. Capital Expense		
34	Ownership	89,513	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	40,512	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 705,678	40
41	**Income before Income Taxes (line 30 minus line 40)****	(88,515)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (88,515)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 617,163	44
45	Private Pay - Net Inpatient Revenue		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)	$ 617,163	49

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

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

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

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	416	416	11,249	27.04	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	600	600	4,950	8.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,754	1,827	17,093	9.36	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,945	2,105	24,592	11.68	14
15	Cook Helpers/Assistants	499	520	4,865	9.36	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,498	1,560	14,595	9.36	18
19	Laundry	499	520	4,865	9.36	19
20	Administrator	694	694	19,502	28.10	20
21	Assistant Administrator					21
22	Other Administrative	416	416	16,600	39.90	22
23	Office Manager					23
24	Clerical	1,200	1,248	22,586	18.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,000	2,080	31,569	15.18	29
30	Habilitation Aides (DD Homes)	20,356	19,281	184,717	9.58	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	31,877	31,267	$ 357,183 *	$ 11.42	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	55	$ 2,200	1-3	35
36	Medical Director	24	1,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	50	1,255	10-3	38
39	Pharmacist Consultant	12	120	10-3	39
40	Physical Therapy Consultant	26	1,341	10A-3	40
41	Occupational Therapy Consultant	50	3,062	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	38	2,211	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant	48	2,913	12-3	45
46	Other(specify) PSYCHOLOGIST	20	1,475	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	323	$ 16,377		49

C. CONTRACT NURSES

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TONYA D LINDSEY	ADMINISTRATIVE	100%	$ 16,600
ROBIN C CIMERA	ADMINISTRATIVE		19,502
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 36,102

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
KREHBIEL & ASSOCIATES	ACCOUNTING	$ 880
MARSHA D HOLZHAUER, LAW OFFICE OF	LEGAL	1,485
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 2,365

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,522
Unemployment Compensation Insurance	4,732
FICA Taxes	28,895
Employee Health Insurance	14,940
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PHYSICALS, VACCINES, TB TESTS, FLOWERS, HOLIDAY PARTIES, HEALTH SAVINGS	1,890
TOTAL (agree to Schedule V, line 22, col.8)	$ 59,979

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	223
Health Care Worker Background Check	142
(Indicate # of checks performed 6)	
Patient Background Checks	
SECRETARY OF STATE	287
SUBSCRIPTIONS	293
PROF REGULATION	290
MISC	105
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,340

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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

Facility Name & ID Number STUART ESTATES # 0051987 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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? **5**

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

(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. $ **40,512**
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? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
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? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KREHBIEL & ASSOCIATES**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **N/A**

(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.

STUART ESTATES
IDPH LICENSE: 0051987
FISCAL YEAR END 12/31/2013

PAGE 3; LINE 15

1/16/2013	SO IL FAMILY FOOT CARE	16.58
1/29/2013	ADVANCED UROLOGIC SURGEONS	16.15
2/4/2013	BRIAN D HAEUBER DMD	65.00
2/6/2013	MIDWEST EMERGENCY DEPT	14.30
2/26/2013	MARION EYE CENTER LTD	102.00
2/26/2013	JUST FOR KIDS DENTAL	144.00
3/15/2013	BRIAN D HAEUBER DMD	182.00
3/15/2013	SMGS MEDICAL GROUP	131.00
3/25/2013	BRIAN D HAEUBER DMD	77.00
3/29/2013	HAMILTON MEMORIAL HOSPITAL	616.20
3/29/2013	BRIAN D HAEUBER DMD	77.00
4/1/2013	BRIAN D HAEUBER DMD	105.00
4/4/2013	JONATHAN W BURTON DMD	520.00
4/11/2013	BRIAN D HAEUBER DMD	77.00
4/12/2013	HAMILTON MEMORIAL HOSPITAL	122.00
4/13/2013	BRIAN D HAEUBER DMD	77.00
5/21/2013	CROSSROADS PHYSICIAN CORP	7.30
6/13/2013	CROSSROADS PHYSICIAN CORP	14.04
6/20/2013	MIDAMERICA RADIOLOGY SC	23.61
6/24/2013	LINCOLN WOODROME DMD	125.00
6/25/2013	CROSSROADS PHYSICIAN CORP	7.30
6/26/2013	BRIAN D HAEUBER DMD	119.34
6/28/2013	ROBERT BRADY MD LLC	173.00
6/30/2013	CAPE RADIOLOGY GROUP	15.42
7/14/2013	SMGS MEDICAL GROUP	74.00
7/18/2013	MIDAMERICA RADIOLOGY SC	79.70
8/6/2013	BRIAN D HAEUBER DMD	79.00
8/13/2013	BRIAN D HAEUBER DMD	29.00
8/20/2013	BRIAN D HAEUBER DMD	40.00
8/23/2013	ROBERT BRADY MD LLC	130.00
8/23/2013	SO IL FAMILY FOOT CARE	8.33
8/29/2013	JUST FOR KIDS DENTAL	167.00
9/3/2013	BRIAN D HAEUBER DMD	79.00
9/16/2013	BRIAN D HAEUBER DMD	115.00
9/30/2013	CAPE RADIOLOGY GROUP	16.65

10/1/2013	BRIAN D HAEUBER DMD	79.00
10/2/2013	SO IL ANESTHESIOLOGY LTD	53.35
10/4/2013	SO IL FAMILY FOOT CARE	14.11
10/8/2013	BRIAN D HAEUBER DMD	79.00
10/9/2013	BRIAN D HAEUBER DMD	105.00
10/9/2013	HAMILTON MEMORIAL HOSPITAL	9.70
10/13/2013	BRIAN D HAEUBER DMD	158.00
10/21/2013	BRIAN D HAEUBER DMD	239.00
10/23/2013	BRIAN D HAEUBER DMD	57.00
10/31/2013	CROSSROADS PHYSICIAN CORP	8.39
11/21/2013	BRIAN D HAEUBER DMD	79.00
11/30/2013	HAMILTON MEMORIAL HOSPITAL	48.85
12/1/2013	MARION EYE CENTER LTD	83.35
12/3/2013	SMGS MEDICAL GROUP	104.00
12/5/2013	CROSSROADS PHYSICIAN CORP	8.39
12/16/2013	BRIAN D HAEUBER DMD	65.00
12/27/2013	BARNES JEWISH HOSPITAL	148.63
	TOTAL DENTAL/VISION/POD	4,984.69

STUART ESTATES
IDPH LICENSE: 0051987
FISCAL YEAR END 12/31/2013

DETAIL FOR PAGE 3; LINE 25

This represents 50% administrative use of the facility vehicle for gas, oil, and repairs expense. The vehicle is used daily for grocery shopping, maintenance, and administrator travel in addition to being used for clients. Daily client transportation to and from the day program is provided by the Day Program Agency.

GAS	4788
REPAIRS	456
MISC	5
TOTAL	5249

STUART ESTATES
IDPH LICENSE: 0051987
FISCAL YEAR END 12/31/2013

DETAIL FOR PAGE 7; COLUMN 5

OWNER	BELLE MANOR	MEADOWBROOK ESTATES	STUART ESTATES	SUTTON HOUSE	TRAFFORD ESTATES	TOTALS
TONYA D LINDSEY						
SALARY	16,600	16,600	16,600	16,600	16,600	83,000
DIRECTORS FEE	4,000	4,000	4,000	4,000	4,000	20,000
	20,600	20,600	20,600	20,600	20,600	103,000

STUART ESTATES
IDPH LICENSE: 0051987
FISCAL YEAR END 12/31/2013

PAGE 23; QUESTION 12

For the facility to properly care for the residents in a manner consistent with State regulations, it is necessary for the habilitation aides to additionally undertake the following assignments for the time period indicated.

LAUNDREY	2 Hours/Day
COOK'S HELPER	2 Hours/Day
HOUSEKEEPING	6 Hours/Day
ACTIVITY	7 Hours/Day