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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049718

Facility Name: Galena Stauss Nursing Home

Address: 215 Summit Street (Number) Galena (City) 61036 (Zip Code)

County: Jo Daviess

Telephone Number: (815) 776-1340 **Fax #** (815) 776-7274

HFS ID Number:

Date of Initial License for Current Owners: 01-01-1970

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 20-4560540			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Marie Wamsley **Telephone Number:** (815) 776-7277
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/14 to 09/30/15 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) Tracy Bauer
(Title) Chief Executive Officer

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Paul Traczek, CPA, Partner
(Firm Name & Address) Wipfli LLP, 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701
(Telephone) (715) 858-6619 Fax # (715) 832-2345

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	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			55	55	8
9	SNF/PED					9
10	ICF	10,640	4,488		15,128	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,640	4,488	55	15,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.98%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 5 and days of care provided 55

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: N/A Fiscal Year: 09/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	135,010		15,150	150,160		150,160		150,160			1
2	Food Purchase		179,210		179,210		179,210		179,210			2
3	Housekeeping	42,071		9,523	51,594		51,594		51,594			3
4	Laundry			62,607	62,607		62,607		62,607			4
5	Heat and Other Utilities			34,119	34,119		34,119		34,119			5
6	Maintenance	24,809		33,263	58,072		58,072		58,072			6
7	Other (specify):*											7
8	TOTAL General Services	201,890	179,210	154,662	535,762		535,762		535,762			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,139,221		153,390	1,292,611		1,292,611		1,292,611			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Incontinent Supplies			68,473	68,473		68,473		68,473			15
16	TOTAL Health Care and Programs	1,139,221		221,863	1,361,084		1,361,084		1,361,084			16
	C. General Administration											
17	Administrative	18,288		13,326	31,614		31,614		31,614			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	3,185		2,321	5,506		5,506		5,506			21
22	Employee Benefits & Payroll Taxes			319,332	319,332		319,332		319,332			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	21,473		334,979	356,452		356,452		356,452			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,362,584	179,210	711,504	2,253,298		2,253,298		2,253,298			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Galena Stauss Nursing Home #0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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			49,384	49,384	24,020	73,404		73,404			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					32,863	32,863		32,863			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			56,883	56,883	(56,883)						36
37	**TOTAL Ownership**			106,267	106,267		106,267		106,267			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	8,438			8,438		8,438		8,438			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,888	77,888		77,888		77,888			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	8,438		77,888	86,326		86,326		86,326			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,371,022	179,210	895,659	2,445,891		2,445,891		2,445,891			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Galena Stauss Nursing Home

ID# 0049718

Report Period Beginning: 10/01/14

Ending: 09/30/15

	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 Galena Stauss Nursing Home **#** 0049718 **Report Period Beginning:** 10/01/14 **Ending:** 09/30/15

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 Galena Stauss Nursing Home # 0049718 **Report Period Beginning:** 10/01/14 **Ending:** 09/30/15

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 Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

	1 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1			X	Construction of New Hospital		10/01/06	$ 45,485,000	$ 44,370,000	10/01/2046	6.7500	$ 32,863	1
2				Administration is located in								2
3				new facility. Interest reported								3
4				relates to the NH's portion of								4
5				the administrative offices.								5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 45,485,000	$ 44,370,000			$ 32,863	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 45,485,000	$ 44,370,000			$ 32,863	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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 Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Galena Stauss Nursing Home COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 0049718

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,191 B. General Construction Type: Exterior Brick Frame Block 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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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	57		1962	1971	$ 172,407	$	41	$	$	$ 172,407	4
5				1981	57,844		Various			57,844	5
6				1988	171,482	16,331	Various	16,331		151,257	6
7				2007	847,453	42,470	Various	42,470		308,678	7
8											8
	Improvement Type**										
9	CURB.GUTTER&SDWLK-FRONT ENT			04/01/81	1,003	-	12	-		1,003	9
10	PARKING LOT EXPAN.			04/01/81	7,150	-	12	-		7,150	10
11	CONCRETE PARKING LOT			04/01/89	1,376	-	15	-		1,376	11
12	GAZEBO			04/01/89	1,282	-	15	-		1,282	12
13	SIDEWALKS-SPROULE			04/01/90	716	-	15	-		716	13
14	LANDSCAPING			03/31/04	1,209	-	10	-		1,209	14
15	CONCRETE DRIVEWAY			04/01/91	720	-	15	-		720	15
16	LANDSCAPING COURTYARD			04/01/91	1,261	-	10	-		1,261	16
17	PAVE PARKING LOT			04/01/94	1,902	-	12	-		1,902	17
18	PHYSICAL THERAPY/HELIO PAD			04/01/95	2,284	-	8	-		2,284	18
19	14 CAR BUMPERS			04/01/96	222	-	5	-		222	19
20	PARKING LOT			06/01/00	25,239	1,122	15	1,122		25,169	20
21	CEDAR PRIVACY FENCE			04/01/01	1,885	-	8	-		1,885	21
22	132 SHRUBS			03/01/02	1,421	-	5	-		1,421	22
23	LANDSCAPING			03/31/02	929	-	10	-		929	23
24	2 TREES			03/31/02	132	7	20	7		89	24
25	WOODEN FENCE AROUND HVAC			03/31/02	593	-	8	-		593	25
26	MOVING/FLATING OF BACKFILL			03/31/02	1,704	-	5	-		1,704	26
27	HANDICAP ENTRANCE			03/31/02	739	49	15	49		665	27
28	REPAIR TO SIDEWALK (CLINIC/NH)			03/31/02	1,136	76	15	76		1,022	28
29	MOVING/FLATTENING OF BACKFILL			11/29/02	373	-	5	-		373	29
30	TWO BRONZE PLAQUES			03/20/03	324	-	10	-		324	30
31	SHRUBS/LANDCAPING/MULCHING			06/05/03	1,672	-	10	-		1,672	31
32	RESURFACE PARKING LOT			07/08/03	1,392	58	12	58		1,392	32
33	LANDSCAPING/SHRUBS/MULCH			07/23/03	406	-	10	-		406	33
34	PARKING LOT			07/25/05	2,848	-	8	-		2,848	34
35	LANDSCAPING & PARKING LOT			06/01/00	39,208	1,743	15	1,743		39,099	35
36	9 SHRUBS			03/31/02	98	-	5	-		98	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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	2 TREES	03/31/02	$ 75	$ 4	20	$ 4	$	$ 51	37
38	LANDSCAPING	03/31/02	538	-	10	-		538	38
39	MULCH	03/31/02	64	-	10	-		64	39
40	BULLET EDGING	07/31/03	264	-	5	-		264	40
41	LANDSCAPING	07/31/03	1,185	-	10	-		1,185	41
42	SHRUBS	07/31/03	1,378	-	5	-		1,378	42
43	STOREROOM	04/01/70	11,787	-	42	-		11,787	43
44	AIR CONDITIONING	04/01/74	6,324	-	20	-		6,324	44
45	VARIOUS ADDITIONS	04/01/74	1,317	-	35	-		1,317	45
46	STOREROOM & MTC-GENERAL	04/01/75	35,868	-	34	-		35,868	46
47	STOREROOM & MTC-ELECTRICAL	04/01/75	3,825	-	20	-		3,825	47
48	STOREROOM & MTC-MECHANICAL	04/01/75	8,222	-	25	-		8,222	48
49	STOREROOM & MTC-SPRINKLER	04/01/75	1,481	-	25	-		1,481	49
50	STORM WINDOWS & SCREENS-1962	04/01/77	1,031	-	32	-		1,031	50
51	HEATING,VENTING,& AIR COND	04/01/82	1,150	-	8	-		1,150	51
52	INSULATION	04/01/82	5,661	-	15	-		5,661	52
53	ENCLOSED PORCH PATIO	04/01/82	2,975	-	15	-		2,975	53
54	RENOVATION OF C.S. AREA	04/01/83	1,067	-	20	-		1,067	54
55	224 CORRIDOR HANDRAIL	04/01/84	1,435	-	25	-		1,435	55
56	DIETARY REMODELING	04/01/84	1,384	-	25	-		1,384	56
57	REMOTE THERMOSTATS	04/01/85	1,587	-	20	-		1,587	57
58	GENERAL CONTRACT	04/01/85	32,281	-	24	-		32,281	58
59	ELECTRICAL	04/01/85	19,623	-	20	-		19,623	59
60	MECHANICAL	04/01/85	29,729	-	20	-		29,729	60
61	MILLWORK	04/01/85	11,688	-	20	-		11,688	61
62	NEW ROOM-GIESE	04/01/86	11,426	-	10	-		11,426	62
63	12-NEW WINDOWS-GREENCO	04/01/87	3,873	-	12	-		3,873	63
64	REMODELING-OLD N.H.	04/01/88	1,308	-	20	-		1,308	64
65	MILLWORK-BLDG ADD'N	05/01/88	5,952	-	20	-		5,927	65
66	PLUMBING-BLDG ADD'N	05/01/88	24,990	-	20	-		24,885	66
67	HEATING & A/C-BLDG ADD'N	05/01/88	24,438	-	20	-		24,336	67
68	ELECTRICAL-BLDG ADD'N	05/01/88	29,353	-	20	-		29,230	68
69	FIRE ALARM SYSTEM	04/01/89	9,342	-	15	-		9,342	69
70	**TOTAL (lines 4 thru 69)**		**$ 1,641,031**	**$ 61,860**		**$ 61,860**	**$**	**$ 1,081,242**	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,641,031	$ 61,860		$ 61,860	$	$ 1,081,242	1
2	AIR CONDITIONING REPLACEMENT	04/01/89	8,507	-	10	-		8,507	2
3	BOILER REPLACEMENT	04/01/89	21,149	-	20	-		21,149	3
4	INSULATION	04/01/90	948	-	10	-		948	4
5	NEW DOORS-GREENCO	04/01/90	2,740	-	15	-		2,740	5
6	DOOR ALARM SYSTEM	04/01/91	750	-	15	-		750	6
7	REMODELING-N.H.	04/01/94	2,881	-	20	-		2,881	7
8	DRAIN LINE UNDER FLOOR	04/01/96	1,819	-	10	-		1,819	8
9	ELECTRICAL-RADIOLOGY REMODEL	04/01/96	13,502	-	18	-		13,502	9
10	GENERAL-RADIOLOGY REMODELING	04/01/96	31,216	1,561	20	1,561		30,436	10
11	HELIPORT LIGHTING	04/01/96	1,511	-	15	-		1,511	11
12	ROOF IMPROVEMENT	04/01/97	856	-	10	-		856	12
13	PHYSICAL THERAPY ROOM REMODEL	04/01/97	4,169	208	20	208		3,857	13
14	HEATING AND A/C UNITS	04/01/99	1,649	-	10	-		1,649	14
15	2 STANLEY MAGIC AUTOMATIC DOORS	04/01/99	1,221	-	10	-		1,221	15
16	REBUILD CHILLER	04/01/99	3,666	-	10	-		3,666	16
17	FIRE ALARM IMPROVEMENTS	04/01/00	1,376	-	10	-		1,376	17
18	ARMSTRONG TILE FLOORING FOR DIETARY	04/01/00	1,287	64	20	64		998	18
19	FIRE ALARM SYSTEM-ADMINISTRATION	04/01/01	905	60	15	60		874	19
20	REMODELING-BUSINESS OFFICE	04/01/01	63,452	4,230	15	4,230		61,337	20
21	HOOD & EXHAUST WORK - DIETARY	04/01/01	907	45	20	45		657	21
22	RADIOLOGY REMODEL	03/31/02	23,995	1,600	15	1,600		21,596	22
23	NURSING HOME NEW CEILING	03/31/02	2,789	-	10	-		2,789	23
24	NURSING HOME SHOWER FLOORS	03/31/02	471	24	20	24		318	24
25	NURSING HOME REMODEL	11/04/02	3,088	-	10	-		3,088	25
26	NURSING HOME THERMOSTATS & ELECTRIC	01/09/03	2,428	-	10	-		2,428	26
27	AUTOMATIC ENTRANCE MED-SURG	01/28/03	7,501	-	5	-		7,501	27
28	ADMINISTRATION REMODEL	03/26/03	5,491	366	15	366		4,575	28
29	NURSING HOME FIRE DOOR	03/31/03	1,310	-	10	-		1,310	29
30	HOSPITAL GENERATOR POWER SOURCE	03/31/03	4,990	-	5	-		4,990	30
31	ELECTRICAL WORK	10/31/03	3,736	187	20	187		2,148	31
32	WATER HEATERS	10/31/03	844	-	10	-		844	32
33	FLOORING	10/31/03	927	-	5	-		927	33
34	**TOTAL (lines 1 thru 33)**		**$ 1,863,112**	**$ 70,205**		**$ 70,205**	**$**	**$ 1,294,490**	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,863,112	$ 70,205		$ 70,205	$	$ 1,294,490	1
2	DENSITOMETER ROOM	03/31/04	4,102	-	5	-		4,102	2
3	CIRCULATING BOOSTER PUMP	04/30/04	2,708	-	10	-		2,708	3
4	PT REMODEL	05/01/04	8,044	536	15	536		6,167	4
5	AUTOMATIC DOOR	07/01/04	778	-	10	-		778	5
6	CT REMODEL	05/20/05	58,451	2,923	20	2,923		30,687	6
7	CARPET-EDUCATION ROOM	07/19/05	464	-	5	-		464	7
8	WOOD FLOORING-DINING ROOMS	07/19/05	781	39	10	39		781	8
9	MAMMOGRAM ROOM REMODEL	08/30/05	3,430	229	15	229		2,401	9
10	REMODELING-GENERAL	04/01/94	52,851	1,957	27	1,957		42,085	10
11	PLUMBING	04/01/94	4,680	-	20	-		4,680	11
12	HEATING,VENTING,AIR COND.	04/01/94	11,049	-	20	-		11,049	12
13	ELECTRICAL	04/01/94	21,537	-	20	-		21,537	13
14	PAINTING	04/01/94	650	-	10	-		650	14
15	SUSPENDED CEILING	04/01/94	2,919	-	12	-		2,919	15
16	CABINETS	04/01/94	7,332	-	20	-		7,332	16
17	FLOOR COVERINGS	04/01/94	4,840	-	10	-		4,840	17
18	ELEVATOR	04/01/94	11,876	-	20	-		11,876	18
19	HAND RAIL FOR PHYSICAL THERAPY	12/17/02	303	20	15	20		253	19
20	EXTENSION JOINT	11/03/04	530	-	5	-		530	20
21	ELEVATOR PROCESSOR BOARD	12/01/05	981	-	5	-		972	21
22	ER REMODEL/SHOWER ROOM	01/01/06	1,671	111	15	111		1,082	22
23	GARAGE DOOR	07/01/06	436	44	10	44		402	23
24	FLOORING	09/22/06	233	23	10	23		221	24
25	HEATING	09/30/07	2,126	142	15	142		1,205	25
26	SPRINKLER SYSTEM	09/30/07	22,634	905	25	905		7,696	26
27	SPRINKLER SYSTEM	09/30/07	2,220	89	25	89		755	27
28	HVAC UNIT	09/30/07	7,044	470	15	470		3,991	28
29	PLASTIC CULVERT PIPE	09/30/07	1,470	74	20	74		625	29
30	Building Components/Remodeling - 2007 Nursing Home	12/05/07	1,381	69	20	69		541	30
31	Deck	09/30/10	4,998	500	10	500		2,749	31
32	Flooring	09/30/10	421	42	10	42		231	32
33	Windows and Doors	09/30/10	5,307	265	20	265		1,459	33
34	**TOTAL (lines 1 thru 33)**		**$ 2,111,359**	**$ 78,643**		**$ 78,643**	**$**	**$ 1,472,258**	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,111,359	$ 78,643		$ 78,643	$	$ 1,472,258	1
2	Landscaping	12/02/11	738	105	7	105		369	2
3	Replace Flat Roof at NH	10/24/11	48,500	4,850	10	4,850		16,975	3
4	Replace Kitchen Ceiling in NH	11/16/11	2,358	236	10	236		825	4
5	Carpet and Flooring - Resident Rooms in NH	07/13/12	6,802	1,360	5	1,360		4,761	5
6	Flooring - Vinyl - NH Dining Room and Nurses Station	07/13/12	3,892	389	10	389		1,362	6
7	Resident Room Faucets in NH Patient Rooms	11/23/12	2,098	105	20	105		262	7
8	Resident Room Vanity Countertops in NH Patient Rooms	12/30/12	1,146	76	15	76		191	8
9	Flashed Roof Top Duct Work on NH Building	05/30/13	477	48	10	48		119	9
10	Flooring	04/08/15	3,176	159	10	159		159	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	TOTAL (lines 1 thru 33)		$ 2,180,546	$ 85,971		$ 85,971	$	$ 1,497,281	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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	$ 291,696	$ 28,666	$ 28,666	$		$ 139,638	71
72	Current Year Purchases	151,259	5,527	5,527			5,527	72
73	Fully Depreciated Assets	134,995	1,842	1,842			134,995	73
74								74
75	TOTALS	$ 577,950	$ 36,035	$ 36,035	$		$ 280,160	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,758,496	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 122,006	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 122,006	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,777,441	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 5,609 Description: Copier and special single use equipment for residents (oxygen canisters, equipment, etc.)
    (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 39 Col 1	56 hrs	8,438				56	8,438	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			$ 8,438		$	$	56	$ 8,438	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/15 (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	$ 1,504,781	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,308,517)	3,995,172		3
4	Supply Inventory (priced at)	367,858		4
5	Short-Term Investments	1,922,488		5
6	Prepaid Insurance	140,804		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other receivables	206,622		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,137,725	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,608,074		12
13	Land	559,916		13
14	Buildings, at Historical Cost	42,601,350		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	11,492,278		16
17	Accumulated Depreciation (book methods)	(24,837,847)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Gift Fund	18,712		22
23	Other(specify): Bond issuance costs & intangible	804,519		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 36,247,002	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 44,384,727	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 817,807	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	542,039		29
30	Accrued Salaries Payable	513,002		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,497,488		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Amounts payable to Medicare	400,000		36
37	Security deposits and deferred revenue	429,717		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,200,053	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	182,763		39
40	Mortgage Payable			40
41	Bonds Payable	43,919,154		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred revenue	1,120,628		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 45,222,545	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 49,422,598	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,037,871)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 44,384,727	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,145,589)	1
2	Restatements (describe):		2
3	**Opening net assets to balance to audit reports - 2013 amendment**	(1,433,622)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,579,211)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(545,901)	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) **Interest Income & Contributions**	113,899	15
16	Other (describe) **Loans forgiven from temp restricted net assets**	(26,658)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (458,660)	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)**	$ (5,037,871)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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	$ 3,489,395	1
2	Discounts and Allowances for all Levels	(977,249)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,512,146	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)**	$ 2,512,146	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	535,762	31
32	Health Care	1,361,084	32
33	General Administration	356,452	33
	B. Capital Expense		
34	Ownership	106,267	34
	C. Ancillary Expense		
35	Special Cost Centers	8,438	35
36	Provider Participation Fee	77,888	36
	D. Other Expenses (specify):		
37	Hospital net loss	612,156	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,058,047	40
41	**Income before Income Taxes (line 30 minus line 40)****	(545,901)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (545,901)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,383,545	44
45	Private Pay - Net Inpatient Revenue	1,091,971	45
46	Medicare - Net Inpatient Revenue	36,630	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,512,146	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,152	2,181	$ 73,886	$ 33.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,832	3,883	94,856	24.43	3
4	Licensed Practical Nurses	11,651	11,807	244,687	20.72	4
5	CNAs & Orderlies	41,667	42,225	527,083	12.48	5
6	CNA Trainees					6
7	Licensed Therapist	13	13	363	27.92	7
8	Rehab/Therapy Aides	3,096	3,138	30,841	9.83	8
9	Activity Director	2,054	2,081	26,854	12.90	9
10	Activity Assistants	1,477	1,497	16,910	11.30	10
11	Social Service Workers	1,745	1,769	28,965	16.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,205	11,317	135,010	11.93	15
16	Dishwashers					16
17	Maintenance Workers	1,425	1,439	24,089	16.74	17
18	Housekeepers	3,650	3,687	42,082	11.41	18
19	Laundry					19
20	Administrator	1,855	1,880	68,095	36.22	20
21	Assistant Administrator					21
22	Other Administrative	1	1	18	18.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,133	2,161	27,372	12.67	31
32	Other Health C: Physical Therapist	271	275	8,438	30.68	32
33	Other(specify) Allocated Admin	431	431	21,473	49.82	33
34	TOTAL (lines 1 - 33)	88,658	89,785	$ 1,371,022 *	$ 15.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tracy Bauer	CEO		$ 20,242
Hesper Nowatski	NH DON - OLD		55,828
Carrie Temperly	NH DON - NEW		22,125
(Amounts are allocated - see separate cost report for allocation to AL and ADC)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,195

B. Administrative - Other

Description	Amount
Supplies and allocated administrative expenses	$ 15,647
TOTAL (agree to Schedule V, line 17, col. 3)	$ 15,647
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Allocated benefits from Medicare cost report	315,687
TOTAL (agree to Schedule V, line 22, col.8)	$ 315,687

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

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)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/14 Ending: 09/30/15

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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **15**

(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. $ **77,888**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **89,622**

(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? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wipfli LLP**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A - No legal fees related to the NH in 2015**
Attach invoices and a summary of services for all architect and appraisal fees.