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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

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

<p>I. IDPH Facility ID Number: <u>0037531</u></p> <p>Facility Name: <u>Curtiss Court</u></p> <p>Address: <u>2883 S. Taylor</u> <u>Springfield</u> <u>62703</u> Number City Zip Code</p> <p>County: <u>Sangamon</u></p> <p>Telephone Number: <u>(217) 585-1199</u> Fax # <u>217-585-1188</u></p> <p>IDPA ID Number: <u>37-1079626052</u></p> <p>Date of Initial License for Current Owners: <u>11/19/91</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/99</u> to <u>09/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date)</td> </tr> <tr> <td></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) <u>Tim Bledsoe</u></td> </tr> <tr> <td></td> <td data-bbox="1291 803 1950 868">(Title) <u>Director of Operations</u></td> </tr> <tr> <td data-bbox="1155 868 1291 1031">Paid Preparer</td> <td data-bbox="1291 868 1950 933">(Signed) <u>See Attached Independent Accountant's Report</u> (Date)</td> </tr> <tr> <td></td> <td data-bbox="1291 933 1950 998">(Print Name and Title) <u>McGladrey & Pullen, LLP</u></td> </tr> <tr> <td></td> <td data-bbox="1291 998 1950 1063">(Firm Name & Address) <u>117 East Main Street, Suite 210 P.O. Box 1070, Galesburg, IL 61401</u></td> </tr> <tr> <td></td> <td data-bbox="1291 1063 1950 1123">(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date)		(Type or Print Name) <u>Tim Bledsoe</u>		(Title) <u>Director of Operations</u>	Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Date)		(Print Name and Title) <u>McGladrey & Pullen, LLP</u>		(Firm Name & Address) <u>117 East Main Street, Suite 210 P.O. Box 1070, Galesburg, IL 61401</u>		(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
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SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number Curtiss Court

0037531 Report Period Beginning: 10/01/99 Ending: 09/30/00

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total
		Public Aid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,661	0		5,661
14	TOTALS	5,661			5,661

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.67%

D. How many bed-hold days during this year were paid by Public Aid? 117 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/19/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/22/91 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/00 Fiscal Year: 9/30/00

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Curtiss Court # 0037531 Report Period Beginning: 10/01/99 Ending: 09/30/00

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	30,881	2,544	2,580	36,005		36,005		36,005		1
2	Food Purchase		22,829		22,829	(627)	22,202		22,202		2
3	Housekeeping	19,128	2,385	618	22,131		22,131		22,131		3
4	Laundry		1,852		1,852		1,852		1,852		4
5	Heat and Other Utilities			8,419	8,419		8,419		8,419		5
6	Maintenance	3,405	2,896	4,694	10,995		10,995		10,995		6
7	Other (specify):*										7
8	TOTAL General Services	53,414	32,506	16,311	102,231	(627)	101,604		101,604		8
	B. Health Care and Programs										
9	Medical Director			3,900	3,900		3,900		3,900		9
10	Nursing and Medical Records	126,245	3,750	6,558	136,553		136,553		136,553		10
10a	Therapy			400	400		400		400		10a
11	Activities		1,373	1,359	2,732		2,732	(416)	2,316		11
12	Social Services			550	550		550		550		12
13	Nurse Aide Training	3,062			3,062		3,062		3,062		13
14	Program Transportation			338	338	786	1,124		1,124		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	129,307	5,123	13,105	147,535	786	148,321	(416)	147,905		16
	C. General Administration										
17	Administrative	13,283			13,283		13,283		13,283		17
18	Directors Fees							232	232		18
19	Professional Services			28,440	28,440		28,440	(4,515)	23,925		19
20	Dues, Fees, Subscriptions & Promotions			2,053	2,053		2,053	208	2,261		20
21	Clerical & General Office Expenses	7,883	2,823	3,350	14,056		14,056	389	14,445		21
22	Employee Benefits & Payroll Taxes			32,913	32,913	627	33,540	2,269	35,809		22
23	Inservice Training & Education			666	666		666	220	886		23
24	Travel and Seminar			467	467		467	132	599		24
25	Other Admin. Staff Transportation			1,572	1,572	(786)	786	261	1,047		25
26	Insurance-Prop.Liab.Malpractice			4,625	4,625		4,625	386	5,011		26
27	Other (specify):* Attached Sch VIII			201	201		201	(201)			27
28	TOTAL General Administration	21,166	2,823	74,287	98,276	(159)	98,117	(619)	97,498		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	203,887	40,452	103,703	348,042		348,042	(1,035)	347,007		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

Curtiss Court

#0037531

Report Period Beginning:

10/01/99

Ending:

09/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			839	839		839	495	1,334			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			8,421	8,421		8,421		8,421			33
34	Rent-Facility & Grounds			66,705	66,705		66,705	112	66,817			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Attach Sch VIII											36
37	TOTAL Ownership			75,965	75,965		75,965	607	76,572			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			35,144	35,144		35,144		35,144			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,144	35,144		35,144		35,144			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	203,887	40,452	214,812	459,151		459,151	(428)	458,723			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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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		V-30		9
10	Interest and Other Investment Income		V-32		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	(17)	V-27		24
25	Fund Raising, Advertising and Promotional		V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule IX	(932)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (949)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule See Attached Sch III	521		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 521		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (428)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Curtiss Court ID# 0037531
 Report Period Beginning: 10/01/99
 Ending: 09/30/00

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
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76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90 Total		0	90

Facility Name & ID Number Curtiss Court

0037531

Report Period Beginning: 10/01/99

Ending: 09/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None		See Attached Schedule I		None		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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 Curtiss Court # 0037531 Report Period Beginning: 10/01/99 Ending: 09/30/00

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1									\$		1	
2	See Attached Schedules II & III								232		18-7	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$ 232			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 Curtiss Court # 0037531 Report Period Beginning: 10/01/99 Ending: 09/30/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Community Living Options, Inc.
 Street Address 239 South Cherry Street
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-7777
 Fax Number (309) 343-1469

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

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	See Attached Schedules II & III							14,766	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 14,766	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Curtiss Court # 0037531 Report Period Beginning: 10/01/99 Ending: 09/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2	None											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$		\$		9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$		\$		14
15	TOTALS (line 9+line14)						\$	\$		\$		15

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: 0 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A -Facility Leased</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated
	Beds*	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation
4	16			\$	\$		\$	\$	\$
5									
6									
7									
8									
9	Improvement Type**								
10	Leasehold Improvements:								
11	None								
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36	TOTAL (lines 4 thru 35)			\$	\$		\$	\$	\$

*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.

Facility Name & ID Number Curtiss Court

0037531

Report Period Beginning: 10/01/99

Ending: 09/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 3,426	\$ 566	\$ 566		5-10 yrs	\$ 3,296	37
38	Current Year Purchases	1,875	273	273		5	273	38
39	Fully Depreciated Assets							39
40	Indirect Costs Allocated (See Attached Sch III)		495	495				40
41	TOTALS	\$ 5,301	\$ 1,334	\$ 1,334	\$		\$ 3,569	41

D. Vehicle Depreciation (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	
42	Patient Care	91 Ford Van	1993	\$ 9,720	\$	\$	\$	4 yrs	\$ 9,720	42
43										43
44										44
45										45
46	TOTALS			\$ 9,720	\$	\$	\$		\$ 9,720	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 15,021	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 1,334	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 1,334	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 13,289	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CMA Partnership #1

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building: <u>1991</u>	<u>16</u>	<u>10/22/91</u>	\$ <u>66,705</u>	<u>11</u>	<u>5</u>	3
4	Additions						4
5							5
6							6
7	TOTAL	16		\$ 66,705			7

10. Effective dates of current rental agreement:

Beginning 10/22/91

Ending 08/17/02

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

Fiscal Year Ending Annual Rent

12. 09/30/2001 \$ 66,630

13. 09/30/2002 \$ 58,579

14. 09/30/2003 \$ 0

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A None

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ N/A Description: Amount Not Determined

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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 <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>40</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>40</u>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility				
	1	2	3	4	
	Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		3,062		3,062
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 3,062	\$	\$ 3,062
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,062		

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>12</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>12</u>

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Curtiss Court # 0037531 Report Period Beginning: 10/01/99 Ending: 09/30/00
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/00 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	47,136		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,123		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	1,116,586		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,171,995	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,021		16
17	Accumulated Depreciation (book methods)	(13,289)		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): <u>See Attached Schedule VII</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,732	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,173,727	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 9,630	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,253		30
31	Accrued Taxes Payable (excluding real estate taxes)	535		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,985		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 31,403	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 31,403	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,142,324	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,173,727	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 965,754	1
2	Restatements (describe):		2
3	Subsequent audit adjustments:		3
4	Additional revenue due to IDPA rate adjustment	12,478	4
5	Home office dietary supplies allocated	(2,790)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 975,442	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	166,882	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)	\$ 166,882	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)	\$ 1,142,324	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Curtiss Court

0037531

Report Period Beginning: 10/01/99

Ending:

Page 19

09/30/00

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 613,650	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 613,650	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	Nurses Aide Training Reimbursements	3,062	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)	\$ 3,062	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	Activity Fund Income	416	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 416	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 617,128	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	101,544	31
32	Health Care	147,535	32
33	General Administration	90,058	33
B. Capital Expense			
34	Ownership	75,965	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	35,144	36
D. Other Expenses (specify):			
37			37
38	See Attached		38
39	Schedule IV		39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 450,246	40
41	Income before Income Taxes (line 30 minus line 40)**	166,882	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 166,882	43

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

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

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

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

Facility Name & ID Number Curtiss Court

0037531

Report Period Beginning: 10/01/99

Ending: 09/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses		0		3
4	Licensed Practical Nurses				4
5	Nurse Aides & Orderlies	12,576	13,522	107,095	7.92
6	Nurse Aide Trainees	437	437	3,062	7.01
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	3,361	3,614	30,540	8.45
16	Dishwashers				16
17	Maintenance Workers	377	401	3,405	8.49
18	Housekeepers	1,930	2,075	18,782	9.05
19	Laundry			0	19
20	Administrator	327	348	6,027	17.32
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	813	865	6,921	8.00
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,482	1,593	19,150	12.02
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care See Attached				32
33	Other(specify) Schedule IV				33
34	TOTAL (lines 1 - 33)	21,303	22,855	\$ 194,982 *	\$ 8.53

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	***	\$ 2,580	1-3
36	Medical Director	***	3,900	9-3
37	Medical Records Consultant			
38	Nurse Consultant	***	4,533	10-3
39	Pharmacist Consultant			
40	Physical Therapy Consultant	***	200	10a-3
41	Occupational Therapy Consultant	***	150	10a-3
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant	***	50	10a-3
44	Activity Consultant			
45	Social Service Consultant	***	550	12-3
46	Other(specify) Dental Consultant	***	389	10-3
47	Psychological Consultant	***	1,636	10-3
48	*** = Monthly Fee			
49	TOTAL (lines 35 - 48)		\$ 13,988	

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$ None		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

A. Administrative Salaries	Function	Ownership %	Amount
Janet Shelton	Administrator	None	6,027
See Attached Schedule III	Indirect Costs	N/A	7,256
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 13,283

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
	RFMS, Inc.	Administrative Services	23,100
	Community Living Options, Inc.	Support Services	5,340
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 28,440

D. Employee Benefits and Payroll Taxes	Description	Amount
	Workers' Compensation Insurance	\$ 7,232
	Unemployment Compensation Insurance	(53)
	FICA Taxes	15,395
	Employee Health Insurance	8,685
	Employee Meals	627
	Illinois Municipal Retirement Fund (IMRF)*	
	401(k) and other employee benefits	1,654
	Indirect Costs - See Attached Schedule III	2,269
TOTAL (agree to Schedule V, line 22, col.8)		\$ 35,809

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	847
	Health Care Worker Background Check (Indicate # of checks performed 12)	144
	IHCA Dues	610
	Subscriptions and Fees	444
	Advertising - Promotion	
	Other Licenses	8
	Indirect Costs - See Attached Sch III	208
	Less: Public Relations Expense	()
	Non-allowable advertising	(0)
	Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,261

G. Schedule of Travel and Seminar**	Description	Amount
	Out-of-State Travel	\$
	In-State Travel	
	Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)	354
	Seminar Expense	113
	Less: Non-allowable out-of-state travel	(332)
	Indirect Costs - See Attached Sch III	464
	Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)		\$ 599

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
2	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21, Section F
- (3) Did the nursing home make political contributions or payments to a political organization? Yes - IHCA Dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 135 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES No 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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 35,144
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 of Public Aid, 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 benefit: on Schedule V. \$ 627 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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.

SEE ACCOUNTANTS' COMPILATION REPORT