

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

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>0033043</u></p> <p>Facility Name: <u>NEW ATHENS HOME FOR THE AGED</u></p> <p>Address: <u>203 SOUTH JOHNSON STREET</u> <u>NEW ATHENS</u> <u>62264</u> Number City Zip Code</p> <p>County: <u>ST. CLAIR</u></p> <p>Telephone Number: <u>(618) 475-2550</u> Fax # ()</p> <p>IDPA ID Number: <u>371221748001</u></p> <p>Date of Initial License for Current Owners: <u>1/1/1968</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>501c3</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>GARY HOLTGREWE</u> Telephone Number: <u>(618) 475-2550</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>501c3</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>1/1/2004</u> to <u>12/31/2004</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>GARY HOLTGREWE</u></td> </tr> <tr> <td></td> <td data-bbox="1291 803 1950 868">(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td data-bbox="1155 868 1291 1031">Paid Preparer</td> <td data-bbox="1291 868 1950 933">(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 933 1950 998">(Print Name and Title) <u>JEFFREY T. RENNER, CPA</u></td> </tr> <tr> <td></td> <td data-bbox="1291 998 1950 1063">(Firm Name & Address) <u>MOORE, RENNER, & SIMONIN, P.C.</u> <u>3636 NORTH BELT WEST, BELLEVILLE, IL 62226</u></td> </tr> <tr> <td></td> <td data-bbox="1291 1063 1950 1123">(Telephone) <u>(618) 233-5049</u> Fax # <u>(618) 233-1061</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>GARY HOLTGREWE</u>		(Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>JEFFREY T. RENNER, CPA</u>		(Firm Name & Address) <u>MOORE, RENNER, & SIMONIN, P.C.</u> <u>3636 NORTH BELT WEST, BELLEVILLE, IL 62226</u>		(Telephone) <u>(618) 233-5049</u> Fax # <u>(618) 233-1061</u>
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Facility Name & ID Number NEW ATHENS HOME FOR THE AGED# 0033043 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

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	64	Intermediate (ICF)	64	23,424	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,424	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	
		2 Public Aid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	10,191	5,329	0	15,520	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,191	5,329	0	15,520	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 66.26%D. How many bed-hold days during this year were paid by Public Aid?
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)PODIATRY, MEALS, BEAUTY SHOPF. Does the facility maintain a daily midnight census? YESG. 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 1/1/1968J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31 Fiscal Year: 12/31

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	117,306			117,306	5,421	122,727		122,727		1
2	Food Purchase		76,593		76,593		76,593		76,593		2
3	Housekeeping	43,743	8,957		52,700		52,700		52,700		3
4	Laundry	61,478	8,734		70,212		70,212		70,212		4
5	Heat and Other Utilities			59,472	59,472		59,472		59,472		5
6	Maintenance	23,974	22,287		46,261		46,261		46,261		6
7	Other (specify):* KITCHEN SUPPLIES		5,281		5,281		5,281		5,281		7
8	TOTAL General Services	246,501	121,852	59,472	427,825	5,421	433,246		433,246		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	617,077	12,542		629,619	40,383	670,002		670,002		10
10a	Therapy	21,417			21,417	1,801	23,218		23,218		10a
11	Activities	39,469			39,469	532	40,001		40,001		11
12	Social Services	14,375			14,375	2,219	16,594		16,594		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* CARE PLAN COOR	28,277		52,996	81,273	(52,996)	28,277		28,277		15
16	TOTAL Health Care and Programs	720,615	12,542	52,996	786,153	(8,061)	778,092		778,092		16
	C. General Administration										
17	Administrative	54,250			54,250		54,250		54,250		17
18	Directors Fees										18
19	Professional Services			4,129	4,129		4,129		4,129		19
20	Dues, Fees, Subscriptions & Promotions			7,936	7,936		7,936	(1,210)	6,726		20
21	Clerical & General Office Expenses	30,860	18,602	5,115	54,577	2,640	57,217		57,217		21
22	Employee Benefits & Payroll Taxes			159,401	159,401		159,401		159,401		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,384	4,384		4,384		4,384		24
25	Other Admin. Staff Transportation			1,123	1,123		1,123		1,123		25
26	Insurance-Prop.Liab.Malpractice			47,397	47,397		47,397		47,397		26
27	Other (specify):*										27
28	TOTAL General Administration	85,110	18,602	229,485	333,197	2,640	335,837	(1,210)	334,627		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,052,226	152,996	341,953	1,547,175		1,547,175	(1,210)	1,545,965		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			69,846	69,846		69,846		69,846			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			3,869	3,869		3,869	(3,869)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			73,715	73,715		73,715	(3,869)	69,846			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			35,136	35,136		35,136		35,136			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,136	35,136		35,136		35,136			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,052,226	152,996	450,804	1,656,026		1,656,026	(5,079)	1,650,947			45

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

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				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	(1,210)			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 REAL ESTATE TAX	(3,869)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,079)		\$	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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (5,079)		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.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NEW ATHENS HOME FOR THE AGED

ID# 0033043

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

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
ILLINOIS SOUTH CONFERENCE OF THE UNITED CHURCH OF CHRIST	100	NONE		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	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

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										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

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												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

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2003 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.)		\$ 3,869	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$ 3,869	3																								
4. Real Estate Tax accrual used for 2004 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.		\$ 3,869	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td>1,091</td><td>8</td></tr> <tr><td>2000</td><td>3,221</td><td>9</td></tr> <tr><td>2001</td><td>3,295</td><td>10</td></tr> <tr><td>2002</td><td>3,463</td><td>11</td></tr> <tr><td>2003</td><td>3,869</td><td>12</td></tr> </table>	1999	1,091	8	2000	3,221	9	2001	3,295	10	2002	3,463	11	2003	3,869	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2003 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
1999	1,091	8																									
2000	3,221	9																									
2001	3,295	10																									
2002	3,463	11																									
2003	3,869	12																									
FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2003 \$																										
14	PLUS APPEAL COST FROM LINE 5 \$																										
15	LESS REFUND FROM LINE 6 \$																										
16	AMOUNT TO USE FOR RATE CALCULATION \$																										

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NEW ATHENS HOME FOR THE AGED COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0033043

CONTACT PERSON REGARDING THIS REPORT GARY HOLTGREWE

TELEPHONE (618) 475-2550 FAX #: ()

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 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 2003.

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

B. Real Estate Tax Cost Allocation:

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 & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,230 B. General Construction Type: Exterior BRICK Frame _____ 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)

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	40,260	1952	\$ 20,000	1
2	ADJACENT LOT	7,500	1986	7,000	2
3	TOTALS	47,760		\$ 27,000	3

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

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		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	22		1957	\$ 223,618	\$		\$	\$	223,618	4
5	31		1970	320,925	8,023		8,023		259,151	5
6	11		1979	53,990	1,350		1,350		34,419	6
7			1980	97,177	2,429		2,429		59,520	7
8										8
	Improvement Type**									
9	GENERAL		1966	10,431	261		261		9,283	9
10	GENERAL		1967	6,088	152		152		5,297	10
11	GENERAL		1968	4,183	105		105		3,555	11
12	GENERAL		1972	6,897	172		172		5,380	12
13	GENERAL		1973	13,854	346		346		10,529	13
14	GENERAL		1974	4,682	117		117		3,464	14
15	GENERAL		1975	14,081	352		352		10,138	15
16	GENERAL		1976	21,994	550		550		15,396	16
17	GENERAL		1978	2,886	72		72		1,905	17
18	GENERAL		1982	4,197	105		105		2,360	18
19	GENERAL		1983	34,509	863		863		18,548	19
20	GENERAL		1984	26,999	675		675		13,837	20
21	GENERAL		1985	43,436	1,086		1,086		21,175	21
22	GENERAL		1986	72,596	1,815		1,815		33,576	22
23	GENERAL		1987	12,434	311		311		5,440	23
24	GENERAL		1990	37,580	939		939		13,622	24
25	GENERAL		1991	128,213	3,205		3,205		43,272	25
26	GENERAL		1992	52,056	1,301		1,301		16,268	26
27	GENERAL		1993	2,808	70		70		807	27
28	GENERAL		1994	18,866	565		565		5,934	28
29	GENERAL		1995	4,122	106		106		1,005	29
30	FOUNDATION REPAIRS		1996	15,640	401		401		3,409	30
31	KITCHEN RENOVATIONS		2001	595,899	14,897		14,897		59,589	31
32	KITCHEN RENOVATIONS		2002	44,811	1,120		1,120		2,800	32
33	GENERAL		2003	7,927	198		198		320	33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,882,899	\$ 41,586		\$ 41,586	\$	\$ 883,617	70

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

Facility Name & ID Number **NEW ATHENS HOME FOR THE AGED** # **0033043** Report Period Beginning: **1/1/2004** Ending: **12/31/2004**

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	
71	Purchased in Prior Years	\$ 224,807	\$ 26,642	\$ 26,642	\$		\$ 123,625	71
72	Current Year Purchases	13,256	1,376	1,376			1,376	72
73	Fully Depreciated Assets	189,259	241	241			189,259	73
74								74
75	TOTALS	\$ 427,322	\$ 28,259	\$ 28,259	\$		\$ 314,260	75

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	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,337,221	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,845	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,845	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)	\$ 1,197,877	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	6 ASSISTED LIVING UNITS 1991	\$ 253,710	\$ 6,343	\$ 83,513	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 253,710	\$ 6,343	\$ 83,513	91

G. Construction-in-Progress

	Description	Cost	
92	CONSTRUCTION IN PROGR	\$ 3,800	92
93			93
94			94
95		\$ 3,800	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u> </u> /2005	\$ <u> </u>
13.	<u> </u> /2006	\$ <u> </u>
14.	<u> </u> /2007	\$ <u> </u>

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: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

\$ _____

D. NUMBER OF AIDES TRAINED

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

- (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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning: 1/1/2004

Ending:

12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(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	\$ 683,469	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	147,266		3
4	Supply Inventory (priced at)	5,478		4
5	Short-Term Investments			5
6	Prepaid Insurance	60,486		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 896,699	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,000		13
14	Buildings, at Historical Cost	2,140,409		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	427,322		16
17	Accumulated Depreciation (book methods)	(1,281,394)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,313,337	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,210,036	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 14,961	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,400		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,997		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 33,358	\$	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)	\$ 33,358	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,176,678	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,210,036	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,377,631	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,377,631	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(200,953)	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)	\$ (200,953)	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)	\$ 2,176,678	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning: 1/1/2004

Ending:

Page 19

12/31/2004

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	\$ 1,343,919	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,343,919	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,643	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,643	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	72,914	24
25	Interest and Other Investment Income***	11,069	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 83,983	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET RENTAL INCOME	19,528	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,528	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,455,073	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	427,825	31
32	Health Care	786,153	32
33	General Administration	333,197	33
B. Capital Expense			
34	Ownership	73,715	34
C. Ancillary Expense			
35	Special Cost Centers	35,136	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,656,026	40
41	Income before Income Taxes (line 30 minus line 40)**	(200,953)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (200,953)	43

* 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.

Facility Name & ID Number **NEW ATHENS HOME FOR THE AGED**# **0033043**Report Period Beginning: **1/1/2004**Ending: **12/31/2004**

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	1,807	2,063	\$ 47,710	\$ 23.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,911	2,191	41,914	19.13	3
4	Licensed Practical Nurses	9,502	10,518	177,070	16.83	4
5	Nurse Aides & Orderlies	33,828	36,572	350,383	9.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,928	2,080	21,417	10.30	8
9	Activity Director	2,475	2,867	39,469	13.77	9
10	Activity Assistants					10
11	Social Service Workers	1,131	1,251	14,375	11.49	11
12	Dietician					12
13	Food Service Supervisor	1,146	1,370	17,112	12.49	13
14	Head Cook	2,720	2,920	23,749	8.13	14
15	Cook Helpers/Assistants	2,657	2,905	28,560	9.83	15
16	Dishwashers	6,064	6,464	47,885	7.41	16
17	Maintenance Workers	2,114	2,226	23,974	10.77	17
18	Housekeepers	4,400	5,080	43,743	8.61	18
19	Laundry	5,909	6,517	61,478	9.43	19
20	Administrator	1,902	2,126	54,250	25.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,832	2,080	30,860	14.84	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					31
32	Other Health Care(specify)					32
33	Other(specify) CARE PLAN CO	1,603	1,787	28,277	15.82	33
34	TOTAL (lines 1 - 33)	82,929	91,017	\$ 1,052,226 *	\$ 11.56	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	96	\$ 5,421	1,5	35
36	Medical Director	12	6,000	10,5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,160	10,5	39
40	Physical Therapy Consultant	29	1,801	10A,5	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	532	11,5	44
45	Social Service Consultant	50	2,219	12,5	45
46	Other(specify) COMPUTER	12	2,640	21,5	46
47					47
48					48
49	TOTAL (lines 35 - 48)	259	\$ 19,773		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	0	\$ 0	10,5	50
51	Licensed Practical Nurses	278	8,531	10,5	51
52	Nurse Aides	1,388	24,692	10,5	52
53	TOTAL (lines 50 - 52)	1,666	\$ 33,223		53

A. Administrative Salaries	Name	Function	Ownership %	Amount
	GARY HOLTGREWE	ADMINISTRATOR		\$ 54,250
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				
				\$ 54,250

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
	MOORE, RENNER & SIMONIN, P. AUDIT		\$ 3,600
	GREENSFELDER, HEMPKER & GLEGAL		529
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			
			\$ 4,129

D. Employee Benefits and Payroll Taxes	Description	Amount
	Workers' Compensation Insurance	\$ 46,443
	Unemployment Compensation Insurance	16,488
	FICA Taxes	78,722
	Employee Health Insurance	15,979
	Employee Meals	
	Illinois Municipal Retirement Fund (IMRF)*	
	UNIFORMS	1,769
TOTAL (agree to Schedule V, line 22, col.8)		
		\$ 159,401

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	3,615
	Health Care Worker Background Check (Indicate # of checks performed <u>20</u>)	254
	LIFE SERVICES NETWORK	2,631
	MES DUES	90
	COUNCIL FOR HHS	1,316
	DIRECTOR OF NURSING DUES	30
	Less: Public Relations Expense	(1,210)
	Non-allowable advertising ()	
	Yellow page advertising ()	
TOTAL (agree to Sch. V, line 20, col. 8)		
		\$ 6,726

G. Schedule of Travel and Seminar**	Description	Amount
	Out-of-State Travel	\$
	In-State Travel	
	Seminar Expense	4,384
	Entertainment Expense ()	
TOTAL (agree to Sch. V, line 24, col. 8)		
		\$ 4,384

* Attach copy of IMRF notifications

**See instructions.

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. LSN \$2631 COUNCIL FOR HHS \$1316
- (3) Did the nursing home make political contributions or payments to a political 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? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 35,136
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department 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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: MOORE, RENNER & SIMONIN, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (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.

NEW ATHENS HOME FOR THE AGED
Schedule of Reclassifications on Pages 3 & 4
2004

	Line #	Dr	Cr
1) Dietary	1	\$ 5,421	
Nursing & Medical Records	10	\$ 40,383	
Therapy	10a	\$ 1,801	
Activities	11	\$ 532	
Social Services	12	\$ 2,219	
Clerical & General Office Expenses	21	\$ 2,640	
Other	15		\$ 52,996

To reclassify outside services to
proper accounts