



Facility Name & ID Number Galena Stauss Nursing Home# 0049718 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,862</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF		<u>15,419</u>		<u>15,419</u>	8
9	SNF/PED					9
10	ICF	<u>4,457</u>			<u>4,457</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,457</u>	<u>15,419</u>		<u>19,876</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.27%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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

G. Do pages 3 &amp; 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 01/01/1970

J. 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: N/A Fiscal Year: 09/30/2008

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	222,527		41,878	264,405		264,405		264,405			1
2	Food Purchase		168,230		168,230		168,230		168,230			2
3	Housekeeping	35,854		17,458	53,312		53,312		53,312			3
4	Laundry	2,046		48,046	50,092		50,092		50,092			4
5	Heat and Other Utilities			39,093	39,093		39,093		39,093			5
6	Maintenance	21,924		17,604	39,528		39,528		39,528			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>282,351</b>	<b>168,230</b>	<b>164,079</b>	<b>614,660</b>		<b>614,660</b>		<b>614,660</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	1,276,321		3,942	1,280,263		1,280,263		1,280,263			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <b>Incontinent Supplies</b>		29,400		29,400		29,400		29,400			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,276,321</b>	<b>29,400</b>	<b>3,942</b>	<b>1,309,663</b>		<b>1,309,663</b>		<b>1,309,663</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	62,774		22,056	84,830		84,830		84,830			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	22,233		7,811	30,044		30,044		30,044			21
22	Employee Benefits & Payroll Taxes			289,774	289,774		289,774		289,774			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			13,164	13,164		13,164		13,164			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>85,007</b>		<b>332,805</b>	<b>417,812</b>		<b>417,812</b>		<b>417,812</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,643,679</b>	<b>197,630</b>	<b>500,826</b>	<b>2,342,135</b>		<b>2,342,135</b>		<b>2,342,135</b>			<b>29</b>

\*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.

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			59,582	59,582	27,985	87,567		87,567		30
31	Amortization of Pre-Op. & Org.										31
32	Interest					27,888	27,888	(1,000)	26,888		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>A&amp;G Allocation</b>			55,873	55,873	(55,873)					36
37	<b>TOTAL Ownership</b>			115,455	115,455		115,455	(1,000)	114,455		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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			28,960	28,960		28,960		28,960		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			28,960	28,960		28,960		28,960		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,643,679	197,630	645,241	2,486,550		2,486,550	(1,000)	2,485,550		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718

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**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

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

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

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

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

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

		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Galena Stauss Nursing Home

ID# 0049718

Report Period Beginning: 10/01/2007

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Sch. V Line

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





Facility Name & ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning: 10/01/2007 Ending: 09/30/2008

**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

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 Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

## 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718 Report Period Beginning: 10/01/2007

Ending: 9/30/2008

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	2007 Bonds		X	Construction of New Hospital		10/1/2006	\$ 45,485,000	\$ 45,485,000	10/1/2046	6.7500	\$ 26,888	1					
2				Administration is located in								2					
3				new facility - this portion								3					
4				relates to the NH's portion								4					
5				of the administrative offices.								5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 45,485,000	\$ 45,485,000			\$ 26,888	9					
<b>B. Non-Facility Related*</b>																	
10	Line of Credit Interest		X	Line of Credit for operations		02/01/2008	500,000	500,000	02/01/2009	5.5000	1,000	10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$ 500,000	\$ 500,000			\$ 1,000	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 45,985,000	\$ 45,985,000			\$ 27,888	15					

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 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, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Galena Stauss Nursing Home COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 0049718

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718 Report Period Beginning:

10/01/2007 Ending:

09/30/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 19,191 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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		1962	1962	\$ 140,184	\$ 3,186	47	\$ 3,186		\$ 138,987	4
5				1971	172,403	400	41	400		172,403	5
6				1981	57,843	2,314	Various	2,314		55,722	6
7				1988	171,479	1,935	Various	1,935		85,174	7
8				2007	609,892	27,985	Various	27,985		27,985	8
<b>Improvement Type**</b>											
9		VARIOUS ADDITIONS		04/01/68	2,827	-	7			2,827	9
10		VAR. ADD.		04/01/69	63	-	7			63	10
11		VAR. ADD.		04/01/71	7,134	-	7			7,134	11
12		VAR. ADD.		04/01/72	229	-	15			229	12
13		VAR. ADD.		04/01/73	151	-	10			151	13
14		CURB.GUTTER&SDWLK-FRONT ENT		04/01/81	1,003	-	12			1,003	14
15		PARKING LOT EXPAN.		04/01/81	7,150	-	12			7,150	15
16		LANDSCAPING-HARMS		04/01/83	489	-	10			489	16
17		GRAVEL PARKING LOT		04/01/88	3,096	-	5			3,096	17
18		SIDEWALK		04/01/88	185	-	10			185	18
19		FENCE AROUND CHILLER		04/01/89	226	-	15			226	19
20		SIDEWALKS & CEMENT SLAB		04/01/89	801	-	15			801	20
21		CHAIN LINK FENCE		04/01/89	330	-	15			330	21
22		CONCRETE PARKING LOT		04/01/89	1,376	-	15			1,376	22
23		GAZEBO		04/01/89	1,282	-	15			1,282	23
24		SIDEWALKS-SPROULE		04/01/90	716	-	15			716	24
25		LANDSCAPING		03/31/04	1,209	121	10	121		544	25
26		CONCRETE DRIVEWAY		04/01/91	720	-	15			720	26
27		LANDSCAPING COURTYARD		04/01/91	1,261	-	10			1,261	27
28		PAVE PARKING LOT		04/01/94	1,902	-	12			1,902	28
29		PHYSICAL THERAPY/HELIO PAD		04/1/95	2,284	-	8			2,284	29
30		14 CAR BUMPERS		04/01/96	222	-	5			222	30
31		PARKING LOT		06/01/00	25,239	1,683	15	1,683		13,951	31
32		CEDAR PRIVACY FENCE		04/01/01	1,885	236	8	236		1,767	32
33		132 SHRUBS		03/01/02	1,421	-	5			1,421	33
34		LANDSCAPING		03/31/02	929	93	10	93		604	34
35		2 TREES		03/31/02	132	7	20	7		43	35
36		WOODEN FENCE AROUND HVAC		03/31/02	593	74	8	74		481	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2007 Ending:

09/30/2008

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	MOVING/FLATING OF BACKFILL	03/31/02	\$ 1,704	\$ -	5	\$	\$	\$ 1,704	37
38	HANDICAP ENTRANCE	03/31/02	739	49	15	49		320	38
39	REPAIR TO SIDEWALK (CLINIC/NH)	03/31/02	1,136	76	15	76		492	39
40	MOVING/FLATTENING OF BACKFILL	11/29/02	373	37	5	37		373	40
41	TWO BRONZE PLAQUES	03/20/03	324	32	10	32		178	41
42	SHRUBS/LANDCAPING/MULCHING	06/05/03	1,672	167	10	167		920	42
43	RESURFACE PARKING LOT	07/08/03	1,392	116	12	116		638	43
44	LANDSCAPING/SHRUBS/MULCH	07/23/03	406	41	10	41		223	44
45	PARKING LOT	07/25/05	2,848	356	8	356		1,246	45
46	LANDSCAPING & PARKING LOT	06/01/00	39,207	2,614	15	2,614		21,673	46
47	9 SHRUBS	03/31/02	98	-	5			98	47
48	2 TREES	03/31/02	75	4	20	4		24	48
49	LANDSCAPING	03/31/02	538	54	10	54		350	49
50	MULCH	03/31/02	64	6	10	6		41	50
51	BULLET EDGING	07/31/03	264	26	5	26		264	51
52	LANDSCAPING	07/31/03	1,185	119	10	119		652	52
53	SHRUBS	07/31/03	1,378	138	5	138		1,378	53
54	VARIOUS ADDITIONS	04/01/62	9,558	-	30			9,558	54
55	VAR. ADD.	04/01/69	471	-	20			471	55
56	STOREROOM	04/01/70	11,786	19	42	19		11,786	56
57	AIR CONDITIONING	04/01/70	5,137	-	20			5,137	57
58	AIR CONDITIONING	04/01/74	6,324	-	20			6,324	58
59	VARIOUS ADDITIONS	04/01/74	1,317	38	35	38		1,298	59
60	STOREROOM & MTC-GENERAL	04/01/75	35,867	1,055	34	1,055		35,345	60
61	STOREROOM & MTC-ELECTRICAL	04/01/75	3,825	-	20			3,825	61
62	STOREROOM & MTC-MECHANICAL	04/01/75	8,222	-	25			8,222	62
63	STOREROOM & MTC-SPRINKLER	04/01/75	1,481	-	25			1,481	63
64	VARIOUS ADDITIONS	04/01/75	111	-	25			111	64
65	ELECTRICAL 1975 ADDN	04/01/77	268	-	18			268	65
66	STORM WINDOWS & SCREENS-1962	04/01/77	1,031	32	32	32		1,014	66
67	REMODEL X-RAY ROOM	04/01/81	11,235	401	28	401		11,034	67
68	HEATING,VENTING,& AIR COND	04/01/82	1,150	-	8			1,150	68
69	INSULATION	04/01/82	5,661	-	15			5,661	69
70	<b>TOTAL (lines 4 thru 69)</b>		<b>\$ 1,373,503</b>	<b>\$ 43,414</b>		<b>\$ 43,414</b>	<b>\$</b>	<b>\$ 665,788</b>	<b>70</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2007 Ending: 09/30/2008

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,373,503	\$ 43,414		\$ 43,414	\$	\$ 665,788	1
2	ENCLOSED PORCH PATIO	04/01/82	2,975	-	15			2,975	2
3	RENOVATION OF C.S. AREA	04/01/83	1,067	-	20			1,067	3
4	LIGHT FIXTURES	04/01/84	529	-	10			529	4
5	VINYL WALL COVERING	04/01/84	3,975	-	10			3,975	5
6	224 CORRIDOR HANDRAIL	04/01/84	1,435	57	25	57		1,407	6
7	DIETARY REMODELING	04/01/84	1,384	55	25	55		1,357	7
8	MEDICAL RECORDS REMODELING	04/01/84	603	24	25	24		591	8
9	ELECTRICAL WORK	04/01/85	275	-	20			275	9
10	REMOTE THERMOSTATS	04/01/85	1,587	-	20			1,587	10
11	WALL COVERINGS	04/01/85	3,769	-	10			3,769	11
12	GENERAL CONTRACT	04/01/85	32,280	1,345	24	1,345		31,607	12
13	ELECTRICAL	04/01/85	19,623	-	20			19,623	13
14	MECHANICAL	04/01/85	29,728	-	20			29,728	14
15	MILLWORK	04/01/85	11,687	-	20			11,687	15
16	FLOORING	04/01/85	3,847	-	5			3,847	16
17	PAINTING	04/01/85	6,443	-	5			6,443	17
18	NEW ROOM-GIESE	04/01/86	11,426	-	10			11,426	18
19	REMODELING-NURSERY	04/01/86	223	-	10			223	19
20	PAINTING-TIEGS	04/01/87	1,551	-	5			1,551	20
21	12-NEW WINDOWS-GREENCO	04/01/87	3,873	-	12			3,873	21
22	ROOF REPLACEMENT	04/01/88	1,090	-	10			1,090	22
23	REMODELING-OLD N.H.	04/01/88	1,308	33	20	33		1,308	23
24	FLOOR COVERINGS-BLDG ADD'N	05/01/88	3,859	-	10			3,859	24
25	PAINTING-BLDG ADD'N	05/01/88	7,644	-	5			7,644	25
26	MILLWORK-BLDG ADD'N	05/01/88	5,952	149	20	149		5,927	26
27	PLUMBING-BLDG ADD'N	05/01/88	24,989	625	20	625		24,885	27
28	HEATING & A/C-BLDG ADD'N	05/01/88	24,437	611	20	611		24,335	28
29	ELECTRICAL-BLDG ADD'N	05/01/88	29,352	734	20	734		29,230	29
30	FIRE ALARM SYSTEM	04/01/89	9,342	-	15			9,342	30
31	AIR CONDITIONING REPLACEMENT	04/01/89	8,507	-	10			8,507	31
32	BOILER REPLACEMENT	04/01/89	21,148	1,057	20	1,057		20,620	32
33	INSULATION	04/01/90	948	-	10			948	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,650,359	\$ 48,104		\$ 48,104	\$	\$ 941,023	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2007 Ending:

09/30/2008

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,650,359	\$ 48,104		\$ 48,104	\$	\$ 941,023	1
2	NEW DOORS-GREENCO	04/01/90	2,740	-	15			2,740	2
3	PAINTING-STRUB	04/01/90	601	-	5			601	3
4	DOOR ALARM SYSTEM	04/01/91	750	-	15			750	4
5	REMODELING-N.H.	04/01/92	536	-	10			536	5
6	GARAGE DOOR	04/01/92	513	-	10			513	6
7	REMODELING-N.H.	04/01/94	2,881	144	20	144		2,089	7
8	NEW ROOF-GIESE	04/01/94	2,767	-	10			2,767	8
9	NEW ROOF	04/01/96	20,693	-	10			20,693	9
10	DRAIN LINE UNDER FLOOR	04/01/96	1,819	-	10			1,819	10
11	ELECTRICAL-RADIOLOGY REMODEL	04/01/96	13,501	750	18	750		9,376	11
12	HVAC-RADIOLOGY REMODEL	04/01/96	18,432	1,229	15	1,229		15,360	12
13	GENERAL-RADIOLOGY REMODELING	04/01/96	31,215	1,561	20	1,561		19,510	13
14	HELIPORT LIGHTING	04/01/96	1,511	101	15	101		1,260	14
15	ROOF IMPROVEMENT	04/01/97	856	-	10			856	15
16	PHYSICAL THERAPY ROOM REMODEL	04/01/97	4,169	208	20	208		2,397	16
17	HEATING AND A/C UNITS	04/01/99	1,649	165	10	165		1,567	17
18	2 STANLEY MAGIC AUTOMATIC DOORS	04/01/99	1,221	122	10	122		1,160	18
19	REBUILD CHILLER	04/01/99	3,665	367	10	367		3,482	19
20	FIRE ALARM IMPROVEMENTS	04/01/00	1,376	138	10	138		1,169	20
21	ARMSTRONG TILE FLOORING FOR DIETARY	04/01/00	1,287	64	20	64		547	21
22	FIRE ALARM SYSTEM-ADMINISTRATION	04/01/01	905	60	15	60		452	22
23	REMODELING-BUSINESS OFFICE	04/01/01	63,451	4,230	15	4,230		31,725	23
24	HOOD & EXHAUST WORK - DIETARY	04/01/01	906	45	20	45		340	24
25	RADIOLOGY REMODEL	03/31/02	23,995	1,600	15	1,600		10,398	25
26	NURSING HOME NEW CEILING	03/31/02	2,788	279	10	279		1,813	26
27	NURSING HOME SHOWER FLOORS	03/31/02	471	24	20	24		153	27
28	CARPET-HALLWAY	03/31/02	5,451	-	5			5,451	28
29	NURSING HOME REMODEL	11/04/02	3,088	309	10	309		1,699	29
30	NURSING HOME CARPET	11/20/02	4,742	474	5	474		4,742	30
31	NURSING HOME THERMOSTATS & ELECTRIC	01/09/03	2,428	243	10	243		1,335	31
32	AUTOMATIC ENTRANCE MED-SURG	01/28/03	7,501	750	5	750		7,501	32
33	ADMINISTRATION REMODEL	03/26/03	5,490	366	15	366		2,013	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,883,757	\$ 61,333		\$ 61,333	\$	\$ 1,097,837	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,883,757	\$ 61,333		\$ 61,333	\$	\$ 1,097,837	1
2	NURSING HOME FIRE DOOR	03/31/03	1,310	131	10	131		720	2
3	HOSPITAL GENERATOR POWER SOURCE	03/31/03	4,990	499	5	499		4,990	3
4	ELECTRICAL WORK	10/31/03	3,736	187	20	187		841	4
5	WATER HEATERS	10/31/03	844	84	10	84		380	5
6	FLOORING	10/31/03	927	185	5	185		835	6
7	DENSITOMETER ROOM	03/31/04	4,102	820	5	820		3,692	7
8	CIRCULATING BOOSTER PUMP	04/30/04	2,708	271	10	271		1,219	8
9	PT REMODEL	05/01/04	8,044	536	15	536		2,413	9
10	AUTOMATIC DOOR	07/01/04	778	78	10	78		350	10
11	CT REMODEL	05/20/05	58,450	2,922	20	2,922		10,229	11
12	CARPET-EDUCATION ROOM	07/19/05	464	93	5	93		325	12
13	WOOD FLOORING-DINING ROOMS	07/19/05	781	78	10	78		273	13
14	MAMMOGRAM ROOM REMODEL	08/30/05	3,430	229	15	229		800	14
15	REMODELING-GENERAL	04/01/94	52,850	1,957	27	1,957		28,382	15
16	PLUMBING	04/01/94	4,680	234	20	234		3,393	16
17	HEATING, VENTING, AIR COND.	04/01/94	11,049	552	20	552		8,011	17
18	ELECTRICAL	04/01/94	21,537	1,077	20	1,077		15,614	18
19	PAINTING	04/01/94	650	-	10			650	19
20	SUSPENDED CEILING	04/01/94	2,919	-	12			2,919	20
21	CABINETS	04/01/94	7,332	367	20	367		5,316	21
22	FLOOR COVERINGS	04/01/94	4,840	-	10			4,840	22
23	ELEVATOR	04/01/94	11,876	594	20	594		8,610	23
24	HAND RAIL FOR PHYSICAL THERAPY	12/17/02	303	20	15	20		111	24
25	EXTENSION JOINT	11/03/04	530	106	5	106		371	25
26	ELEVATOR PROCESSOR BOARD	12/01/05	981	196	5	196		547	26
27	ER REMODEL/SHOWER ROOM	01/01/06	1,671	111	15	111		302	27
28	GARAGE DOOR	07/01/06	436	44	10	44		96	28
29	FLOORING	09/22/06	233	23	10	23		58	29
30	HEATING	09/30/07	2,126	142	15	142		213	30
31	SPRINKLER SYSTEM	09/30/07	22,633	905	25	905		1,358	31
32	SPRINKLER SYSTEM	09/30/07	2,220	89	25	89		133	32
33	HVAC UNIT	09/30/07	7,044	470	15	470		704	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,130,231	\$ 74,333		\$ 74,333	\$	\$ 1,206,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,130,231	\$ 74,333		\$ 74,333	\$	\$ 1,206,532	1
2	PLASTIC CULVERT PIPE	09/30/07	1,470	73	20	73		110	2
3	NH BUILDING REMODEL - 2007	12/05/07	1,380	58	20	58		58	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,133,081	\$ 74,464		\$ 74,464	\$	\$ 1,206,700	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

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	\$ 75,532	\$ 12,430	\$ 12,430	\$		\$ 46,326	71
72	Current Year Purchases	141	10	10			10	72
73	Fully Depreciated Assets	35,035	663	663			35,035	73
74								74
75	TOTALS	\$ 110,708	\$ 13,103	\$ 13,103	\$		\$ 81,371	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 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,243,789	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,567	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,567	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)	\$ 1,288,071	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning: 10/01/2007

Ending: 09/30/2008

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home# 0049718Report Period Beginning: 10/01/2007

Ending:

09/30/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 24,325	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>1,200,000</u> )	2,730,546		3
4	Supply Inventory (priced at <u>cost</u> )	312,173		4
5	Short-Term Investments	1,535,119		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	217,028		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other receivables</u>	40,314		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,859,505	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,383,979		12
13	Land	559,916		13
14	Buildings, at Historical Cost	42,580,809		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	9,419,201		16
17	Accumulated Depreciation (book methods)	(9,165,750)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,057		21
22	Other Long-Term Assets (spe <u>Intangible Asset</u>	28,216		22
23	Other(specify): <u>Deferred Financing Costs</u>	926,624		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 52,737,052	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 57,596,557	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 432,543	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	606,351		29
30	Accrued Salaries Payable	509,755		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,535,119		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Deferred Revenue</u>	76,980		36
37	<u>Amounts payable to Medicare</u>	315,000		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 3,475,748	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	63,200		39
40	Mortgage Payable			40
41	Bonds Payable	45,485,000		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 45,548,200	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 49,023,948	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 8,572,609	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 57,596,557	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,320,717	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,320,717	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(4,799,651)	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) <u>Temp Restricted Contributions</u>	74,326	15
16	Other (describe) <u>Loans forgiven from Temp Restricted Net Assc</u>	(22,783)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,748,108)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 8,572,609	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home# 0049718Report Period Beginning: 10/01/2007Ending: 09/30/2008**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,212,788	1
2	Discounts and Allowances for all Levels	(793,376)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,419,412	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,419,412	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	614,660	31
32	Health Care	1,309,663	32
33	General Administration	417,812	33
<b>B. Capital Expense</b>			
34	Ownership	115,455	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	28,960	36
<b>D. Other Expenses (specify):</b>			
37	<b>Hospital Net Loss</b>	4,732,513	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,219,063	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(4,799,651)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (4,799,651)	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning: 10/01/2007

Ending:

09/30/2008

**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	2,123	2,157	\$ 63,876	\$ 29.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,965	7,079	162,852	23.00	3
4	Licensed Practical Nurses	9,089	9,237	174,222	18.86	4
5	CNAs & Orderlies	51,463	52,302	624,060	11.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,839	3,902	32,259	8.27	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,934	1,966	59,851	30.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	1,586	1,612	17,779	11.03	33
34	TOTAL (lines 1 - 33)	76,999	78,255	\$ 1,134,899 *	\$ 14.50	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,400 Line 15
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 90,795  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No 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? N/A
- 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: Wipfli 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. Audit will be finalized in March 2009
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT