



Facility Name & ID Number GROUP HOME #2# 0036939 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

## 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,375</u>	<u>407</u>		<u>5,782</u>
14	TOTALS	<u>5,375</u>	<u>407</u>		<u>5,782</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 98.74%

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

63 (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? 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 07/19/91

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 07/19/91 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 N/A

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name &amp; ID Number

GROUP HOME #2

# 0036939

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	9,032	394	989	10,415		10,415	10,415			1
2	Food Purchase		18,806		18,806		18,806	18,806			2
3	Housekeeping	16,001	2,423		18,424		18,424	18,424			3
4	Laundry										4
5	Heat and Other Utilities			12,738	12,738		12,738	12,738			5
6	Maintenance	21,813	1,317	5,570	28,700		28,700	28,700			6
7	Other (specify):* SECURITY	3,221	111	4,304	7,636		7,636	7,636			7
8	<b>TOTAL General Services</b>	50,067	23,051	23,601	96,719		96,719	96,719			8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	203,972	3,074		207,046	(11,833)	195,213	195,213			10
10a	Therapy										10a
11	Activities	4,094	3,207	405	7,706		7,706	7,706			11
12	Social Services			2,023	2,023		2,023	2,023			12
13	CNA Training					11,833	11,833	11,833			13
14	Program Transportation	5,903			5,903		5,903	5,903			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	213,969	6,281	2,428	222,678		222,678	222,678			16
	<b>C. General Administration</b>										
17	Administrative	17,807		1,402	19,209		19,209	19,209			17
18	Directors Fees										18
19	Professional Services			7,046	7,046		7,046	7,046			19
20	Dues, Fees, Subscriptions & Promotions			4,397	4,397		4,397	4,397			20
21	Clerical & General Office Expenses	24,534	2,048	5,916	32,498		32,498	32,498			21
22	Employee Benefits & Payroll Taxes			79,298	79,298		79,298	79,298			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			14,909	14,909		14,909	14,909			26
27	Other (specify):* FUND RAISING										27
28	<b>TOTAL General Administration</b>	42,341	2,048	112,968	157,357		157,357	157,357			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	306,377	31,380	138,997	476,754		476,754	476,754			29

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

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

Facility Name &amp; ID Number

GROUP HOME #2

#0036939

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

## 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			22,703	22,703		22,703		22,703			30
31	Amortization of Pre-Op. & Org.			1,136	1,136		1,136		1,136			31
32	Interest			36,019	36,019		36,019		36,019			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS			2,586	2,586		2,586		2,586			36
37	<b>TOTAL Ownership</b>			62,444	62,444		62,444		62,444			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			38,770	38,770		38,770		38,770			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			38,770	38,770		38,770		38,770			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	306,377	31,380	240,211	577,968		577,968		577,968			45

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

Facility Name & ID Number GROUP HOME #2

# 0036939

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

**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 <u>REAL ESTATE TAXES</u>				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	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. (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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

GROUP HOME #2

ID# 0036939

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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





**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
		BEVERLY FARM FOUNDATION				
		GROUP HOME #1				
		GROUP HOME #3				
		GROUP HOME #4				
		GROUP HOME #5				
		GROUP HOME #6				

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.

Facility Name & ID Number GROUP HOME #2 # 0036939 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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

Facility Name & ID Number GROUP HOME #2# 0036939 Report Period Beginning: 07/01/2007Ending: 6/30/2008

## 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

Name of Related Organization BEVERLY FARM FOUNDATION & GROUP HOMES #1 & #3-#6  
 Street Address GODFREY IL 62035  
 City / State / Zip Code ( 618 ) 466-0367  
 Phone Number ( 618 ) 466-3652  
 Fax Number

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

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	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	\$ 3,675,534	\$ 216	\$ 79,298	1
2	17-3	SCHOOL REIMBURSEMENT	WAGES	10,000	8	51,453	272	1,402	2
3	17-1	ADMINISTRATIVE SALARIES	HOURS	2,080	8	213,913	213,913	10,696	3
4	21-1	PERSONNEL/ACCOUNTING	HOURS	2,080	8	490,683	490,683	24,534	4
5	6-1	MAINTENANCE STAFF	HOURS	2,080	8	436,255	436,255	21,813	5
6	7-3	SECURITY/SAFETY	HOURS	2,080	8	86,087	104	4,304	6
7	7-1	SAFETY MANAGER	HOURS	2,080	8	64,426	64,426	3,221	7
8	7-2	SECURITY SUPPLIES	HOURS	2,080	8	2,228	104	111	8
9	6-2	MAINTENANCE SUPPLIES	HOURS	2,080	8	26,343	104	1,317	9
10	21-2	OSHA REQUIREMENTS	HOURS	2,080	8	29,099	104	1,455	10
11	21-3	CONSULTANTS	HOURS	2,080	8	89,599	104	4,480	11
12	11-3	ACTIVITIES OTHER	HOURS	2,080	8	8,092	104	405	12
13	26-3	INSURANCE	HOURS	2,080	8	298,180	104	14,909	13
14	19-3	LEGAL & ACCOUNTING	HOURS	2,080	8	140,912	104	7,046	14
15	14-1	TRANSPORTATION STAFF	HOURS	2,080	8	118,061	118,061	5,903	15
16	20-3	DUES/SUBS/ADVERTISING	HOURS	2,080	8	108,564	84	4,399	16
17	36-3	MORTGAGE INSURANCE	HOURS	2,080	8	51,728	104	2,586	17
18	32-3	INTEREST	HOURS	2,080	8	720,381	104	36,019	18
19	31-3	BOND COSTS AMORT	HOURS	2,080	8	22,726	104	1,136	19
20	6-3	MAINTENANCE - OTHER	HOURS	2,080	8	82,830	102	4,062	20
21	11-1	ACTIVITIES STAFF	HOURS	2,080	8	81,888	81,888	4,094	21
22	11-2	ACTIVITIES SUPPLIES/OTH	HOURS	2,080	8	7,857	104	393	22
23									23
24									24
25	TOTALS					\$ 6,806,839	\$ 1,405,226	\$ 233,583	25

Facility Name & ID Number

GROUP HOME #2

# 0036939

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

**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				
		<b>A. Directly Facility Related</b>										
<b>Long-Term</b>												
1	IL HEALTH FACILITY		X	CONSTRUCTION		07/96	\$	\$ 512,316	2031	6.6800	\$ 36,019	1
2												2
3												3
4												4
5												5
<b>Working Capital</b>												
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$ 512,316			\$ 36,019	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 512,316			\$ 36,019	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 2,586 Line # 36-3

\* 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.)



**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,

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

FACILITY NAME GROUP HOME #2 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0036939

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

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

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

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 direct 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 GROUP HOME #2

# 0036939

Report Period Beginning:

07/01/2007 Ending:

06/30/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 5,112 B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories ONE

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>	<u>10,000</u>		<u>\$ 5,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>10,000</b>		<b>\$ 5,000</b>	<b>3</b>

Facility Name &amp; ID Number GROUP HOME #2

# 0036939

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

**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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16			1991	\$ 380,640	\$ 9,516	40	\$ 9,516	\$	\$ 160,979	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		BUS SHELTER		1996	188		5			188	9
10		ADMINISTRATION BUILDING		1997	55,609	1,390	40	1,390		15,988	10
11		HARDWARE		1998	546	52	10	52		546	11
12		SECURITY SYSTEM		1998	171	19	10	19		171	12
13		DOOR		1999	985	99	10	99		838	13
14		DOORS		2000	2,609	261	10	261		1,957	14
15		FIRE ALARM PANEL		2002	897	90	10	90		494	15
16		DIGITAL THERMOMETER		2003	778	78	10	78		428	16
17		CARPET		2004	4,318	863	5	863		3,886	17
18		TILE FLOORING - SWITCHBOARD AREA		2005	63	6	10	6		21	18
19		TRAINING BUILDING ALLOCATION		1998	1,481	98	15	98		972	19
20		ROOF		2006	11,174	559	20	559		1,397	20
21		KITCHEN CABINETS		2006	6,511	651	10	651		1,628	21
22		REAR DOOR		2006	1,585	159	10	159		397	22
23		CARPET		2007	1,949	389	5	389		778	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number GROUP HOME #2

# 0036939

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	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)	\$	469,504	\$	14,230		\$	14,230	\$	190,668	70

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

Facility Name & ID Number GROUP HOME #2 # 0036939 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	\$ 20,892	\$ 2,088	\$ 2,088		5-10	\$ 15,454	71
72	Current Year Purchases	3,863	386	386		5-10	386	72
73	Fully Depreciated Assets	52,156				5-10	52,156	73
74								74
75	TOTALS	\$ 76,911	\$ 2,474	\$ 2,474	\$		\$ 67,996	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	SEE ATTACHED SCHEDULE			\$ 43,957	\$ 5,999	\$ 5,999		5-10	\$ 29,373	76
77										77
78										78
79										79
80	TOTALS			\$ 43,957	\$ 5,999	\$ 5,999	\$		\$ 29,373	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)	\$ 595,372	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,703	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,703	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)	\$ 288,037	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.

**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

\*\*

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

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 \$ \_\_\_\_\_

\* 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.

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>72</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>88</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		225		225
3	Classroom Wages (a)		4,860		4,860
4	Clinical Wages (b)		5,940		5,940
5	In-House Trainer Wages (c)		808		808
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 11,833	\$	\$ 11,833
10	SUM OF line 9, col. 1 and 2 (e)	\$	11,833		

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	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>9</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.

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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number **GROUP HOME #2**# **0036939**Report Period Beginning: **07/01/2007**

Ending:

**06/30/2008****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2008**

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,358,388		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,358,388	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	469,504		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	120,868		16
17	Accumulated Depreciation (book methods)	(288,037)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 307,335	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,665,723	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	512,316		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 512,316	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 512,316	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,153,407	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,665,723	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,043,854</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,043,854</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>109,553</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>109,553</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,153,407</b>	<b>24</b> *

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

Facility Name &amp; ID Number GROUP HOME #2

# 0036939

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

**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	\$ 687,521	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 687,521	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>	\$ 687,521	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	96,719	31
32	Health Care	222,678	32
33	General Administration	157,357	33
<b>B. Capital Expense</b>			
34	Ownership	62,444	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	38,770	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 577,968	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	109,553	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 109,553	43

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

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

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

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

Facility Name & ID Number **GROUP HOME #2**

# **0036939**

Report Period Beginning:

**07/01/2007**

Ending:

**06/30/2008**

**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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	10,449	14,026	180,371	12.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	311	404	4,094	10.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,770	2,169	9,032	4.16	15
16	Dishwashers					16
17	Maintenance Workers	1,543	1,786	21,813	12.21	17
18	Housekeepers	2,054	2,054	16,001	7.79	18
19	Laundry					19
20	Administrator	451	481	12,139	25.24	20
21	Assistant Administrator	112	112	3,308	29.54	21
22	Other Administrative	201	219	4,029	18.40	22
23	Office Manager					23
24	Clerical	1,959	2,169	22,864	10.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,512	1,680	23,602	14.05	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>SEE ATTACHED</u>	845	899	9,124	10.15	33
34	TOTAL (lines 1 - 33)	21,207	25,999	\$ 306,377 *	\$ 11.78	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	24	\$ 989	1-3	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	81	2,023	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	105	\$ 3,012		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





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. IL HEALTH CARE ASSN \$531
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. N/A
- (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. \$ 38,770  
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. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
  - c. What percent of all travel expense relates to transportation of nurses and patients? 0
  - d. Have vehicle usage logs been maintained? YES
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
  - g. Does the facility transport residents to and from day training? YES  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: SCHEFFEL & COMPANY PC 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. N/A
- (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? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

GROUP HOME 2 - #0036939  
PAGE 20, SCHEDULE XVIII, LINE 33  
JUNE 30, 2008

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
TRANSPORTATION	696	748	\$ 5,903	7.89
SAFETY & SECURITY	149	151	3,221	21.33
	845	899	\$ 9,124	

GROUP HOME 2 - #0036939  
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.  
JUNE 30, 2008

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
1995 CHEVY VAN #7	1,260	-	-	1,260
SUPPLY LUMINA	791	-	-	791
MAINTENANCE #2 TRUCK	707	-	-	707
LIFT ON VAN # 10	256	-	-	256
CAR # 4 REPAIRS	208	-	-	208
MAINT #3 AND SPREADER	596	-	-	596
VAN #6 FORD E350	751	-	-	751
MAINT #1 DUMP TRUCK	1,200	-	-	1,200
MAINT #7 -BUCKET TRUCK	450	-	-	450
TRANSPORT-IDOT VAN #12	2,694	269	269	2,290
TRANS MAINT #4-F150	330	-	-	330
TRANSP-15 PASS. VAN #1	1,709	171	171	1,111
FORD FOCUS-CAR #1	545	-	-	545
IDOT VAN #15	2,218	222	222	1,220
IDOT VAN #16	2,218	222	222	1,220
TRANS-VAN # 13	1,245	249	249	1,121
Trans- Car # 6	197	39	39	177
TRANS. CAR # 3	76	15	15	68
TRANS. MAINT #6 -TRUCK	299	60	60	269
IDOT BUS-VAN #17	4,384	877	877	3,946
MAINT. #8 F350 TRUCK	1,329	266	266	1,196
WHEELCHAIR VAN #5	1,825	365	365	1,643
BUS RENNOVATIONS	259	52	52	233
E-350 Van #19-15 pass.	1,369	274	274	958
E-350 Van #18-15 pass.	1,362	272	272	954
Supply Van Mats	11	2	2	8
2005 GMC-VAN # 3-15 pass.	1,415	283	283	990
2005 GMC-VAN # 11-15 pass.	1,417	283	283	992
IDOT VAN-#8	1,835	184	184	459
Truck for Maintenance	257	51	51	128
Wheelchair Straps for Van #17	32	6	6	16
2006 Chrysler Van #21	833	167	167	416
2006 Chrysler Van #10	867	173	173	434
Wheelchair Van # 20	1,697	339	339	848
Security Car	660	132	132	198
Maintenance Truck w/Snow Plow	1,670	335	335	501
Transportation Van	1,804	361	361	541
Vans-Wheelchair Strap	121	24	24	36
Transportation Van	1,432	143	143	143
IDOT Van	1,628	163	163	163
	<u>43,957</u>	<u>5,999</u>	<u>5,999</u>	<u>29,373</u>