



Facility Name & ID Number Henderson County Retirement Center

# 0035246 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>59</u>	Skilled (SNF)	<u>59</u>	<u>21,594</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>59</u>	TOTALS	<u>59</u>	<u>21,594</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>847</u>	<u>847</u>	8
9	SNF/PED					9
10	ICF	<u>8,567</u>	<u>9,177</u>		<u>17,744</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,567</u>	<u>9,177</u>	<u>847</u>	<u>18,591</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.09%

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

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

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 06/28/89

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

YES  Date 05/16/89 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 54 and days of care provided 847

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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	134,095	13,220	5,216	152,531		152,531		152,531		1
2	Food Purchase		127,389		127,389		127,389	(578)	126,811		2
3	Housekeeping	48,473	8,360		56,833		56,833		56,833		3
4	Laundry	19,875	4,361	17,053	41,289		41,289		41,289		4
5	Heat and Other Utilities			81,700	81,700		81,700		81,700		5
6	Maintenance	43,348	4,404	51,725	99,477		99,477		99,477		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	245,791	157,734	155,694	559,219		559,219	(578)	558,641		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,480	14,480		14,480		14,480		9
10	Nursing and Medical Records	725,378	87,875	4,158	817,411		817,411		817,411		10
10a	Therapy	21,070	1,021	53,336	75,427		75,427		75,427		10a
11	Activities	51,359	5,163	1,475	57,997		57,997		57,997		11
12	Social Services	31,693	260	1,475	33,428		33,428		33,428		12
13	CNA Training										13
14	Program Transportation		9,603		9,603		9,603		9,603		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	829,500	103,922	74,924	1,008,346		1,008,346		1,008,346		16
	<b>C. General Administration</b>										
17	Administrative	52,673			52,673		52,673		52,673		17
18	Directors Fees										18
19	Professional Services			42,092	42,092		42,092		42,092		19
20	Dues, Fees, Subscriptions & Promotions			23,890	23,890		23,890	(16,447)	7,443		20
21	Clerical & General Office Expenses	55,238	9,453	14,969	79,660		79,660		79,660		21
22	Employee Benefits & Payroll Taxes			230,567	230,567		230,567		230,567		22
23	Inservice Training & Education			1,372	1,372		1,372		1,372		23
24	Travel and Seminar			1,556	1,556		1,556		1,556		24
25	Other Admin. Staff Transportation		1,067		1,067		1,067		1,067		25
26	Insurance-Prop.Liab.Malpractice			54,566	54,566		54,566		54,566		26
27	Other (specify):*			529	529		529	(50)	479		27
28	<b>TOTAL General Administration</b>	107,911	10,520	369,541	487,972		487,972	(16,497)	471,475		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,183,202	272,176	600,159	2,055,537		2,055,537	(17,075)	2,038,462		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 & ID Number Henderson County Retirement Center #0035246 Report Period Beginning: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			110,639	110,639		110,639	(12,093)	98,546			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,017	54,017	106	54,123	(18,428)	35,695			32
33	Real Estate Taxes			169	169		169	(169)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,636	3,636		3,636		3,636			35
36	Other (specify):*			600	600		600		600			36
37	<b>TOTAL Ownership</b>			169,061	169,061	106	169,167	(30,690)	138,477			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		189	7,418	7,607		7,607		7,607			40
41	Coffee and Gift Shops		6,518		6,518		6,518		6,518			41
42	Provider Participation Fee			32,392	32,392		32,392		32,392			42
43	Other (specify):*			29,739	29,739	(106)	29,633	(18,969)	10,664			43
44	<b>TOTAL Special Cost Centers</b>		6,707	69,549	76,256	(106)	76,150	(18,969)	57,181			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,183,202	278,883	838,769	2,300,854		2,300,854	(66,734)	2,234,120			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 Henderson County Retirement Center

# 0035246

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	(277)	2		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	(97)	30		9
10	Interest and Other Investment Income	(18,428)	32		10
11	Discounts, Allowances, Rebates & Refunds	(301)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(50)	27		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	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,412)	43		24
25	Fund Raising, Advertising and Promotional	(16,447)	20		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	(13,622)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (66,734)</b>		<b>\$</b>	<b>30</b>

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>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (66,734)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Henderson County Retirement Center

ID# 0035246

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Expenses	\$ (1,457)	43	1
2	Non-Care Related Property Taxes	(169)	33	2
3	Lease Buy-out	(11,996)	30	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>	(13,622)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning:

01/01/08

Ending:

12/31/08

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(578)	0	0	0	0	0	0	0	0	0	0	(578)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(578)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(578)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(16,447)	0	0	0	0	0	0	0	0	0	0	(16,447)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(50)	0	0	0	0	0	0	0	0	0	0	(50)	27
28	<b>TOTAL General Administration</b>	<b>(16,497)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(16,497)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(17,075)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(17,075)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning:

01/01/08 Ending:

12/31/08

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,093)	0	0	0	0	0	0	0	0	0	0	(12,093)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,428)	0	0	0	0	0	0	0	0	0	0	(18,428)	32
33	Real Estate Taxes	(169)	0	0	0	0	0	0	0	0	0	0	(169)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(30,690)</b>	<b>0</b>	<b>(30,690)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(18,969)	0	0	0	0	0	0	0	0	0	0	(18,969)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(18,969)</b>	<b>0</b>	<b>(18,969)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(66,734)</b>	<b>0</b>	<b>(66,734)</b>	<b>45</b>									

Facility Name & ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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 Henderson County Retirement Center

# 0035246

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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	Security Savings		X	Mortgage	\$5,815.86	04/01/93	\$ 2,000,000	\$	10/29/08	6.2500	\$ 43,382	1								
2	Security Savings		X	Refinance Mortgage	Interest only	10/23/08	849,849	849,849	11/23/09	6.2500	10,186	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Life Services Network		X	Finance Workmens Comp Ins.	\$4,469.40	10/01/08	44,694	29,462	09/30/09	2.0000	159	6								
7	Life Services Network		X	Finance Workmens Comp Ins.	\$4,449.66	10/01/07	44,497		09/30/08	2.0000	396	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$14,734.92		\$ 2,939,040	\$ 879,311			\$ 54,123	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>						\$ 2,939,040	\$ 879,311			\$ 54,123	15								

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	12	
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**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 Henderson County Retirement Center COUNTY Henderson

FACILITY IDPH LICENSE NUMBER 0035246

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 Henderson County Retirement Center

# 0035246 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 18,636 B. General Construction Type: Exterior Brick Frame Wood-Steel 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).

Rental House

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	<u>Care Related</u>	<u>217,600</u>	<u>1988</u>	<u>\$ 15,000</u>	1
2					2
3	<b>TOTALS</b>	<b>217,600</b>		<b>\$ 15,000</b>	<b>3</b>

Facility Name &amp; ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	60		1989	1988	\$ 1,260,000	\$ 42,031	30	\$ 42,000	\$ (31)	\$ 822,173	4
5	6		2000	2000	530,989	13,301	40	13,275	(26)	111,118	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		PARKING LOT/LANDSCAPING	1989		25,102	1,258	20	1,255	(3)	24,338	9
10		LANDSCAPING	1990		937	47	20	47		855	10
11		LAND IMPROVEMENT	1995		1,839	92	20	92		1,272	11
12		BRICK SIGN	1996		12,915	620	20	646	26	8,159	12
13		LAND IMPROVEMENT	1992		2,003	101	20	100	(1)	1,617	13
14		LIGHTNING RODS	1998		3,600	240	15	240		2,540	14
15		NEW SOFFITS	1998		26,138	1,752	15	1,743	(9)	18,399	15
16		PHONE SYSTEM	1998		6,738	449	15	449		4,679	16
17		SIDE WALKS	1998		4,500	226	20	225	(1)	2,297	17
18		ALARM SYSTEM	1998		8,266	625	10	625		8,266	18
19		LAUNDRY/GARAGE BLDG	1999		50,330	3,374	15	3,355	(19)	31,491	19
20		STORAGE BLDG	1999		8,911	597	15	594	(3)	5,575	20
21		NEW ROOF	1999		16,311	1,094	15	1,087	(7)	9,932	21
22		LANDSCAPING	2000		1,706	85	20	85		697	22
23		FURNICE	2001		2,848	285	10	285		2,255	23
24		NEW EXIT	2001		1,645	110	15	110		855	24
25		LANDSCAPING	2002		954	95	10	95		636	25
26		GARAGE/STORAGE BUILDING	2002		12,800	858	15	853	(5)	5,505	26
27		ROOFING/SHINGLES	2003		17,838	1,192	15	1,189	(3)	6,517	27
28		Walk-in Freezer	2007		20,883	1,044	20	1,044		1,131	28
29		Window Tinting	2007		2,985	150	20	149	(1)	175	29
30		Door Closures	2007		4,345	434	10	434	(0)	507	30
31		Window Tinting	2008		1,164	49	20	49		49	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 Henderson County Retirement Center

# 0035246

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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)	\$ 2,025,747	\$ 70,109		\$ 70,026	\$ (83)	\$ 1,071,038	70

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 187,550	\$ 17,918	\$ 17,918	\$	9	\$ 124,257	71
72	Current Year Purchases	51,063	4,567	4,567		9	4,567	72
73	Fully Depreciated Assets	460,153				9	460,153	73
74								74
75	TOTALS	\$ 698,766	\$ 22,485	\$ 22,485	\$		\$ 588,977	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	Care Related	07 Dodge Caravan	2007	17,725	3,545	3,545		5	5,613	77
78	Care Related	99 Ford Taurus	2007	3,675	749	735	(14)	5	1,055	78
79	Care Related	Bus	2008	35,095	1,755	1,755		5	1,755	79
80	TOTALS			\$ 56,495	\$ 6,049	\$ 6,035	\$ (14)		\$ 8,423	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)		\$ 2,796,008	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 98,643	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 98,546	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (97)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,668,438	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	Rental Property	\$ 68,955	\$ 2,344	\$ 2,735	86
87	Rental Property	4,597	130	130	87
88					88
89					89
90					90
91	TOTALS	\$ 73,552	\$ 2,474	\$ 2,865	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

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: \$ 3,636 Description: Copier Rent (\$2217) & Oxygen Lease (\$1418.56)

(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.

**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.

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	<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.

Facility Name & ID Number Henderson County Retirement Center# 0035246Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ 223,285	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	342,603		3
4	Supply Inventory (priced at <u>FIFO</u> )	20,995		4
5	Short-Term Investments	368,215		5
6	Prepaid Insurance	32,451		6
7	Other Prepaid Expenses	4,874		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>	\$ 992,423	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500		13
14	Buildings, at Historical Cost	2,467,695		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	763,590		16
17	Accumulated Depreciation (book methods)	(1,860,087)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>C-I-P</u> )	220,643		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,614,341	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,606,764	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 95,094	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,013		30
31	Accrued Taxes Payable (excluding real estate taxes)	952		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,511		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Group Insurance Withheld</u>	(4,965)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 197,605	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,073,853		39
40	Mortgage Payable			40
41	Bonds Payable			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>	\$ 1,073,853	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,271,458	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,335,306	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,606,764	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,282,380	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,282,380	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	63,121	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) Rental Division Loss	(9,880)	15
16	Other (describe) Assisted Living Loss	(315)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 52,926	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)	\$ 1,335,306	24 *

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

Facility Name & ID Number Henderson County Retirement Center# 0035246Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 2,263,381	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,263,381	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,205	6
7	Oxygen	93	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 17,298	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	7,605	12
13	Barber and Beauty Care	7,371	13
14	Non-Patient Meals	277	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,307	17
18	Sale of Supplies to Non-Patients	(10)	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>	\$ 17,550	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	39,812	24
25	Interest and Other Investment Income***	18,428	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 58,240	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Transportation	1,746	28
28a	See List Attached	5,760	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,506	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,363,975	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	559,219	31
32	Health Care	1,008,346	32
33	General Administration	487,972	33
<b>B. Capital Expense</b>			
34	Ownership	169,061	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	43,864	35
36	Provider Participation Fee	32,392	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,300,854	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	63,121	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 63,121	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 Henderson County Retirement Center

# 0035246

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	1,747	2,088	\$ 48,731	\$ 23.34	1
2	Assistant Director of Nursing	1,210	1,273	24,011	18.86	2
3	Registered Nurses	3,008	3,363	62,643	18.63	3
4	Licensed Practical Nurses	11,597	13,025	208,317	15.99	4
5	CNAs & Orderlies	35,250	37,295	342,522	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,914	2,111	21,070	9.98	8
9	Activity Director	1,730	2,088	24,384	11.68	9
10	Activity Assistants	3,018	3,207	26,975	8.41	10
11	Social Service Workers	1,224	3,017	31,693	10.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,928	2,088	22,466	10.76	14
15	Cook Helpers/Assistants	7,147	7,918	66,285	8.37	15
16	Dishwashers	4,764	5,371	45,344	8.44	16
17	Maintenance Workers	1,820	3,063	43,348	14.15	17
18	Housekeepers	5,634	5,962	48,473	8.13	18
19	Laundry	1,773	1,960	19,875	10.14	19
20	Administrator	1,856	2,168	52,673	24.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,733	4,275	55,238	12.92	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 Care Plan Coord.	1,765	2,007	39,154	19.51	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,118	102,279	\$ 1,183,202 *	\$ 11.57	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	133	\$ 5,216	1-3	35
36	Medical Director	Contract	14,480	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	1,475	11-3	44
45	Social Service Consultant	Contract	1,475	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	133	\$ 24,446		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

Facility Name & ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning: 01/01/08

Ending: 12/31/08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Richard Clifton	Administator	0	\$ 52,673	Workers' Compensation Insurance	\$ 99,000	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	347	
				FICA Taxes	87,606	Health Care Worker Background Check	700	
				Employee Health Insurance	41,128	(Indicate # of checks performed 70 )		
				Employee Meals	258	Patient Background Checks	53	
				Illinois Municipal Retirement Fund (IMRF)*		Adv/Promotion	16,609	
				Adjustment to Vacation Accrual	2,575	LSN Dues	2,499	
						NAEIR Membership Credit	(280)	
						See List Attached	2,490	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 52,673			Less: Public Relations Expense	(12,401)	
(List each licensed administrator separately.)						Non-allowable advertising	(4,046)	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
N/A			\$ 0	\$ 230,567			\$ 7,443	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 0					
(Attach a copy of any management service agreement)								
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
WDM Computer Services	Data Processing		\$ 21,622	N/A		\$ 0	Out-of-State Travel	\$
WDM Computer Services	Consulting		19,970					
Robertson, Wilcox, Alcorn &	Legal		500				In-State Travel	
							Seminar Expense	
							See List Attached	1,556
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 42,092	TOTAL			\$ 1,556	
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. LSN - \$2,499
- (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. \$ 17,374 Line 10-2
- (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. \$ 32,392  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 277
- (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? 90
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Bennett & Middendorf 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 no yet finished.
- (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.

Henderson County Retirement Center, Inc.  
#0035246  
01/01/08 to 12/31/08

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$67.38
REPAIRS & MAINT BUILDING	\$16,431.96
REPAIRS & MAINT EQUIP	\$1,202.13
REPAIRS & MAINT GROUNDS	\$3,835.66
REPAIRS & MAINT LAUNDRY	\$419.90
REPAIRS & MAINT HSK	\$0.00
REPAIRS & MAINT CABLE	\$1,253.82
REPAIRS & MAINT ALARM	\$0.00
REPAIRS & MAINT GEN/ADM	\$1,461.45
OUTSIDE SERVICES	\$16,345.00
REFUSE	\$10,707.55
TOTAL	<u>\$51,724.85</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$7,514.23
Board Minutes	\$200.00
Software Support	\$6,210.00
IVANS Medicare Billings	\$1,044.92
TOTAL	<u>\$14,969.15</u>

Schedule V. Line 14 & 25, Column 2 (90% to line 14)

Auto Exp. & Service	\$3,574.94
Auto Gas & Oil	\$5,914.35
Business Mileage Expense	\$967.70
Bus Driver	<u>\$211.00</u>
	\$10,669.99

Schedule V. Line 43, Column 3

Misc. Exp.	\$1,562.65
Bad Debt	\$28,076.00
Charitable Contributions	<u>\$100.00</u>
	\$29,738.65

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Admissions	\$90.00
Activity Program Income	\$808.34
Uniform Sales	\$5.00
Rebates	\$301.25
Gain on sale of Asset	\$3,300.00
Miscellaneous	\$16.97
Dues	\$1,238.13
Rounding	<u>\$5,759.69</u>

Schedule XIX, Section F.

Henderson County Economic Development	\$600.00
Med-Pass Subscription Service	\$274.50
Stronghurst Booster Club Membership	\$20.00
LTCNA Dues	\$50.00
Misc. Mag./Newspaper Subscriptions	\$595.97
IL Charity Bureau Fund- IL 990 Fee	\$15.00
Sec of State-Filing Fee	\$10.00
Sec of State-Notary Fee	\$20.00
Cobra Serve-Administration Fee	\$396.00
CLIAL Laboratory Program-Certification Fee	\$150.00
Sec of State-License for Ford Taurus	\$143.00
Dept of Health-Sanitation license	\$105.00
Sec of State-License for Van	\$10.00
Sec of State-License for Taurus	\$26.00
Sec of State-Licence for Bus	\$75.00
	<u>\$2,490.47</u>

Henderson County Retirement Center, Inc.

#0035246

01/01/08 to 12/31/08

Board Members

Diana Doran, Pres 2008

Box 417

Carman, IL 61425

Judy Roessler

RR1, Box 11

Media, IL 61460

Sally Fisher 2006

RR 1

Lomax, IL 61454

Tom Edmonds, 2006

RR 1, Box 129

Lomax, IL 61454

John Allaman, Treas. 2007

RR 1

Kirkwood, IL 61447

Tony Griepentrog, 2006

Box 111

Stronghurst, IL 61480

Nancy Stevenson, Sec. 2008

RR 1

Gladstone, IL 61437

Gene Turner

315 W. Main

Stronghurst, IL 61480

Ralph Tatge, 2007 (Vice Pres.)

Box 535

Stronghurst, IL 61480

Honorary Board Members

Laura Kent Donahue

Zach Stamp

Henderson County Retirement Center, Inc.

#0035246

01/01/08 to 12/31/08

Reclassifications

1 Reclassify \$106.00 from Misc exp and into Other Interest for Workman's Compensation

2 Reclassify \$

3 Reclassify \$

4 Reclassify \$

5 Reclassify \$

6 Reclassify \$

Henderson County Retirement Center, Inc.

#0035246

01/01/08 to 12/31/08

Check Date	When Attended	Vendor Name	Name of In-Service	Amount
4/11/2008	4/11/2008	Lari Smith	CPR Training for employees	\$ 270.00
4/24/2008	4/24/2008	Lari Smith	CPR Training for employees	\$ 350.00
1/29/2008	2/5-7/08	Polaris Group	ADR's Part 1 - 3	\$ 327.00
5/31/2008	6/5/2008	Life Service Network	Transforming the Experience Of Elderhood	\$ 119.00
1/31/2008	2/19/2008	Life Service Network	Medicaid Rule Changes-What Does It Mean to You and Your Medicaid Reimbursement	\$ 99.00
1/31/2008			Food Safety Class	\$ 69.00
2/26/2008			Food Safety Class	\$ 138.00
			Total for Year	<b>\$ 1,372.00</b>

Henderson County Retirement Center, Inc.

#0035246

01/01/08 to 12/31/08

Check Date	Who Attended	When Attended	Where Attended	Name of Seminar	Expense	Amount
7/1/2008	Irene Francis	7/1/2008		Insightful Food Safety-Food Sanitation	Registration	\$ 89.00
8/7/2008	Jennifer Schaley	8/7/2008	Moline, IL	Ramirez Consulting Seminar	Mileage	\$ 76.50
	Nancy Oaks	8/7/2008	Moline, IL	Ramirez Consulting Seminar	Mileage	
8/4/2008	Jennifer Schaley	8/7/2008	Moline, IL	Ramirez Consulting Seminar	Registration	\$ 295.00
	Nancy Oaks	8/7/2008	Moline, IL	Ramirez Consulting Seminar	Registration	
9/18/2008	Irene Francis	9/18/2008	Moline, IL	Western IL Area Agency on Aging-2008 Conference	Registration	\$ 120.00
	Jennifer Schaley	9/18/2008	Moline, IL	Western IL Area Agency on Aging-2008 Conference	Registration	
	Dianne Kircher	3/18/2008	Moline, IL	Western IL Area Agency on Aging-2008 Conference	Registration	
9/18/2008	Jennifer Schaley	9/18/2008		Western IL Area Agency on Aging-2008 Conference	Mileage	\$ 72.00
10/10/2008	Jennifer Schaley	10/8/2008	Quincy, IL	Kohl's Food Show	Mileage	\$ 72.00
	Irene Francis	10/8/2008	Quincy, IL	Kohl's Food Show		
10/14/2008	Irene Francis	10/15/2008	Cedar Falls, IA	Martin Bros. Food Show	Mileage	\$ 38.88
10/22/2008	Richard Clifton	11/12/2008	Springfield, IL	Results That last: Sharpen Your Frontline.....LSN	Registration	\$ 450.00
	Jennifer Schaley	11/12/2008	Springfield, IL	Results That last: Sharpen Your Frontline.....LSN	Registration	
	Irene Francis	11/12/2008	Springfield, IL	Results That last: Sharpen Your Frontline.....LSN	Registration	
11/25/2008	Carole Dillon	11/13/2008	Moline, IL	Ramirez Consulting Seminar	Mileage	\$ 47.70
11/26/08	Jennifer Schaley	11/13/2008	Moline, IL	Ramirez Consulting Seminar	Registration	\$ 295.00
	Carole Dillon	11/13/085	Moline, IL	Ramirez Consulting Seminar		
Total for Year						\$ -
						\$ 1,556.08