

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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

<p>I. IDPH License ID Number: <u>0038729</u></p> <p>Facility Name: <u>Autumn Leaves d/b/a Beacon Street Place</u></p> <p>Address: <u>4838 Beacon Drive</u> <u>Decatur</u> <u>62521</u> <small>Number City Zip Code</small></p> <p>County: <u>Macon</u></p> <p>Telephone Number: <u>217-422-1761</u> Fax # ()</p> <p>HFS ID Number: <u>37-1273581</u></p> <p>Date of Initial License for Current Owners: <u>05/24/93</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mark S. Wood, CPA</u> Telephone Number: <u>217-875-2655</u> Email Address: <u>mwood@mckcpa.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Type or Print Name)</td> <td style="border: none;"><u>David M. Jacobus</u></td> </tr> <tr> <td style="border: none;">(Title)</td> <td style="border: none;"><u>Owner</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Print Name and Title)</td> <td style="border: none;"><u>Mark S. Wood, CPA</u></td> </tr> <tr> <td style="border: none;">(Firm Name & Address)</td> <td style="border: none;"><u>May, Cocagne & King, P.C.</u> <u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u></td> </tr> <tr> <td style="border: none;">(Telephone)</td> <td style="border: none;"><u>217-875-2655</u> Fax # <u>217-875-1660</u></td> </tr> </table> <p align="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name)	<u>David M. Jacobus</u>	(Title)	<u>Owner</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title)	<u>Mark S. Wood, CPA</u>	(Firm Name & Address)	<u>May, Cocagne & King, P.C.</u> <u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u>	(Telephone)	<u>217-875-2655</u> Fax # <u>217-875-1660</u>
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<p>I. IDPH License ID Number: <u>0038737</u></p> <p>Facility Name: <u>Autumn Leaves d/b/a Forty-fourth Street Place</u></p> <p>Address: <u>1479 South 44th Street</u> <u>Decatur</u> <u>62521</u> <small>Number City Zip Code</small></p> <p>County: <u>Macon</u></p> <p>Telephone Number: <u>217-422-2773</u> Fax # ()</p> <p>HFS ID Number: <u>37-1273581</u></p> <p>Date of Initial License for Current Owners: <u>05/24/93</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mark S. Wood, CPA</u> Telephone Number: <u>217-875-2655</u> Email Address: <u>mwood@mckcpa.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Type or Print Name)</td> <td style="border: none;"><u>David M. Jacobus</u></td> </tr> <tr> <td style="border: none;">(Title)</td> <td style="border: none;"><u>Owner</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Print Name and Title)</td> <td style="border: none;"><u>Mark S. Wood, CPA</u></td> </tr> <tr> <td style="border: none;">(Firm Name & Address)</td> <td style="border: none;"><u>May, Cocagne & King, P.C.</u> <u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u></td> </tr> <tr> <td style="border: none;">(Telephone)</td> <td style="border: none;"><u>217-875-2655</u> Fax # <u>217-875-1660</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name)	<u>David M. Jacobus</u>	(Title)	<u>Owner</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title)	<u>Mark S. Wood, CPA</u>	(Firm Name & Address)	<u>May, Cocagne & King, P.C.</u> <u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u>	(Telephone)	<u>217-875-2655</u> Fax # <u>217-875-1660</u>
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Facility Name & ID Number Beacon Street Place

0038729 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 03/21/91

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,744			5,744	13
14	TOTALS	5,744			5,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.36%

D. How many bed-hold days during this year were paid by the Department? 97 (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 05/24/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/24/93 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: _____

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

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/09 Ending: 12/31/09

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
	A. General Services										
1	Dietary	11,161	1,132	3,564	15,857		15,857		15,857		1
2	Food Purchase		40,068		40,068	(4,207)	35,861		35,861		2
3	Housekeeping	92,106	5,347		97,453		97,453		97,453		3
4	Laundry		119		119		119		119		4
5	Heat and Other Utilities			21,439	21,439		21,439	4,252	25,691		5
6	Maintenance	13,540	236	11,786	25,562		25,562	107	25,669		6
7	Other (specify):*			5,009	5,009		5,009		5,009		7
8	TOTAL General Services	116,807	46,902	41,798	205,507	(4,207)	201,300	4,359	205,659		8
	B. Health Care and Programs										
9	Medical Director			9,040	9,040		9,040		9,040		9
10	Nursing and Medical Records	206,502	7,106	5,887	219,495		219,495	1,535	221,030		10
10a	Therapy										10a
11	Activities	51,535	5,720		57,255		57,255		57,255		11
12	Social Services	21,384		620	22,004		22,004		22,004		12
13	CNA Training	1,914		2,441	4,355		4,355		4,355		13
14	Program Transportation			6,777	6,777		6,777		6,777		14
15	Other (specify):*			175,733	175,733		175,733	(171,578)	4,155		15
16	TOTAL Health Care and Programs	281,335	12,826	200,498	494,659		494,659	(170,043)	324,616		16
	C. General Administration										
17	Administrative	82,819			82,819		82,819		82,819		17
18	Directors Fees										18
19	Professional Services			20,423	20,423		20,423	549	20,972		19
20	Dues, Fees, Subscriptions & Promotions			1,727	1,727		1,727		1,727		20
21	Clerical & General Office Expenses	10,930	5,286	32,548	48,764		48,764	(19,987)	28,777		21
22	Employee Benefits & Payroll Taxes			53,399	53,399	4,207	57,606		57,606		22
23	Inservice Training & Education										23
24	Travel and Seminar			188	188		188		188		24
25	Other Admin. Staff Transportation			1,686	1,686		1,686		1,686		25
26	Insurance-Prop.Liab.Malpractice			23,305	23,305		23,305		23,305		26
27	Other (specify):*										27
28	TOTAL General Administration	93,749	5,286	133,276	232,311	4,207	236,518	(19,438)	217,080		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	491,891	65,014	375,572	932,477		932,477	(185,122)	747,355		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Beacon Street Place

#0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			14,844	14,844		14,844	22,488	37,332			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,118	6,118		6,118		6,118			32
33	Real Estate Taxes			9,121	9,121		9,121		9,121			33
34	Rent-Facility & Grounds			73,200	73,200		73,200	(73,200)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			103,283	103,283		103,283	(50,712)	52,571			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,130	54,130		54,130		54,130			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,130	54,130		54,130		54,130			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	491,891	65,014	532,985	1,089,890		1,089,890	(235,834)	854,056			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(171,578)	15		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	8,255	30		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	(10,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,323)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(62,511)	Various	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (62,511)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (235,834)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beacon Street Place# 0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	4,252	0	0	0	0	0	0	0	0	0	4,252	5
6	Maintenance	0	107	0	0	0	0	0	0	0	0	0	107	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	4,359	0	4,359	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,535	0	0	0	0	0	0	0	0	0	1,535	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):*	(171,578)	0	0	0	0	0	0	0	0	0	0	(171,578)	15
16	TOTAL Health Care and Programs	(171,578)	1,535	0	(170,043)	16								
	C. General Administration													
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	549	0	0	0	0	0	0	0	0	0	549	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(10,000)	(9,987)	0	0	0	0	0	0	0	0	0	(19,987)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(10,000)	(9,438)	0	(19,438)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(181,578)	(3,544)	0	(185,122)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beacon Street Place# 0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	8,255	1,330	12,903	0	0	0	0	0	0	0	0	22,488	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(73,200)	0	0	0	0	0	0	0	0	(73,200)	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	TOTAL Ownership	8,255	1,330	(60,297)	0	(50,712)	37							
	Ancillary Expense													
	E. Special Cost Centers													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(173,323)	(2,214)	(60,297)	0	0	0	0	0	0	0	0	(235,834)	45

Facility Name & ID Number

Beacon Street Place

0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

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
David M. Jacobus	100	Drew Corp d/b/a Moultrie County Comm Center	Decatur, IL	David Jacobus	Decatur, IL	Central Office
				Central Office		For homes

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	21 General Office	\$ 10,500	David M. Jacobus, Central Office	100.00%	\$ 513	\$ (9,987)	1
2	V	5 Utilities				4,252	4,252	2
3	V	6 Maintenance				107	107	3
4	V	10 Medical Supplies				1,535	1,535	4
5	V	19 Professional Fees				549	549	5
6	V	30 Depreciation				1,330	1,330	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 10,500			\$ 8,286	\$ * (2,214)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Building Rent - Hickory Street	\$ 27,600	David M. Jacobus	100.00%	\$	\$(27,600)
16	V	30 Depreciation - Hickory Street		David M. Jacobus	100.00%	5,081	5,081
17	V						
18	V						
19	V	34 Building Rent - Beacon Street	22,800	David M. Jacobus	100.00%		(22,800)
20	V	30 Depreciation - Beacon Street		David M. Jacobus	100.00%	2,745	2,745
21	V						
22	V						
23	V	34 Building Rent - 44th Street	22,800	David M. Jacobus	100.00%		(22,800)
24	V	30 Depreciation - 44th Street		David M. Jacobus	100.00%	5,077	5,077
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 73,200			\$ 12,903	\$ * (60,297)

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

Facility Name & ID Number

Beacon Street Place

0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	David M. Jacobus	Owner	Various	100.00	27,137	6.5	16.25	Dietary	\$ 6,760	1-1	1
2						13	32.50	Maintenance	15,658	6-1	2
3						10.5	26.25	General Off	10,920	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 33,338		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place

0038729

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization David Jacobus, Central Office
 Street Address 2576 Greenway
 City / State / Zip Code Cerro Gordo, IL 61818
 Phone Number (217) 763-2191
 Fax Number (217) 763-2101

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

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

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	21	General Office	Occupied Bed Days	10,465	2	\$ 935	\$ 0	5,744	\$ 513	1
2	5	Utilities	Occupied Bed Days	10,465	2	7,747	0	5,744	4,252	2
3	6	Maintenance	Occupied Bed Days	10,465	2	195	0	5,744	107	3
4	10	Medical Supplies	Occupied Bed Days	10,465	2	2,797	0	5,744	1,535	4
5	19	Professional Fees	Occupied Bed Days	10,465	2	1,000	0	5,744	549	5
6	30	Depreciation	Occupied Bed Days	10,465	2	2,424	0	5,744	1,330	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					\$ 15,098	\$		\$ 8,286	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Beacon Street Place

0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

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										
										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			
A. Directly Facility Related																			
Long-Term																			
1	Nissan Motor Acceptance		X	2008 Nissan Pathfinder	\$1,088.78	09/07/07	\$ 36,882	\$	09/20/10	3.9000	\$	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	National City Bank		X	Operating Cash	N/A	6/30/09	350,000	149,000	6/30/10	3.2500		6,118	6						
7													7						
8													8						
9	TOTAL Facility Related				\$1,088.78		\$ 386,882	\$ 149,000			\$	6,118	9						
B. Non-Facility Related*																			
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$	\$			\$		14						
15	TOTALS (line 9+line14)						\$ 386,882	\$ 149,000			\$	6,118	15						

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beacon Street Place

0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,400 B. General Construction Type: Exterior Vinyl Frame Wood w/sprinklers 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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Facility</u>	<u>2,400</u>	<u>1998</u>	<u>\$ 27,000</u>	<u>1</u>
2	<u>From Pages 11A & 11B</u>			<u>32,000</u>	<u>2</u>
3	TOTALS	2,400		\$ 59,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place

0038729 Report Period Beginning:

01/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 1,320 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Facility</u>	<u>1,320</u>	<u>1993</u>	<u>\$ 5,000</u>	1
2					2
3	TOTALS	<u>1,320</u>		<u>\$ 5,000</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place

0038729 Report Period Beginning:

01/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,176 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Facility</u>	<u>2,176</u>	<u>1998</u>	<u>\$ 27,000</u>	1
2					2
3	TOTALS	<u>2,176</u>		<u>\$ 27,000</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place

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	6	1998	1991	\$ 198,175	\$ 5,081	25	\$ 7,927	\$ 2,846	\$ 93,142	4
5	4	1993	1960	55,000	1,410	25	2,200	790	36,667	5
6	6	1998	1963	198,000	5,077	25	7,920	2,843	90,420	6
7										7
8										8
Improvement Type**										
9	Landscaping		1991	549		10			550	9
10	Landscaping		1992	3,496		15			3,496	10
11	Flooring		1994	2,931		6			2,931	11
12	Carpet		1994	1,890		6			1,890	12
13	Carpet		1994	1,179		6			1,179	13
14	Landscaping		1995	519	31	15	35	4	494	14
15	Blinds & Curtains		1996	1,795		5			1,795	15
16	Landscaping		1996	2,418	143	10		(143)	2,418	16
17	Office Remodel		2001	2,000	51	15	133	82	1,122	17
18	Office Remodel		2001	2,000	51	15	133	82	1,122	18
19	Office Remodel		2001	1,000		10	100	100	833	19
20	HVAC		2006	4,623	119	15	308	190	1,053	20
21	Roof		2007	6,421	165	20	321	156	883	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Air Conditioner	1995	\$ 1,051	\$ 27	8		\$ (27)	\$ 1,051	37
38	Landscaping	1996	2,418	143	10		(143)	2,418	38
39	Furnace	1996	1,030	26	15	69	42	904	39
40	Landscaping	1996	2,101	124	10		(124)	2,101	40
41	Carpet/Blinds	1997	3,074		5			3,074	41
42	Security System	1993	2,259		15			2,259	42
43	Carpet	1993	1,826		6			1,826	43
44	Flooring	1993	3,547		6			3,547	44
45	Cabinets	1993	2,456		15			2,456	45
46	Office Remodel	1993	44,254	1,135	15		(1,135)	44,254	46
47	Sprinkler System	1993	7,800	200	15		(200)	7,800	47
48	Plumbing	1999	2,053	53	6		(53)	2,053	48
49	Office Remodel	2001	2,000	51	15	133	82	1,122	49
50	Office Remodel	2001	1,000		10	100	100	833	50
51	Roof	2006	10,275	263	10	1,028	764	3,425	51
52	Fire Panel	2008	2,675		10	856	856	1,391	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)		\$ 571,815	\$ 14,150		\$ 21,263	\$ 7,113	\$ 320,510	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 571,815	\$ 14,150		\$ 21,263	\$ 7,113	\$ 320,510	1
2	Asphalt Drive	1993	5,431		16	228	228	5,431	2
3	Carpet	1995	2,094		10			2,094	3
4	Landscaping	1996	2,418	143	10		(143)	2,418	4
5	Furnace	1999	1,285	33	15	86	53	892	5
6	Carpet	2000	1,550		5			1,550	6
7	Office Remodel - Walls	2001	2,000	51	15	133	82	1,122	7
8	Office Remodel - Flooring	2001	2,000		10	200	200	1,667	8
9	Roof	2006	12,611	323	10	1,261	938	4,204	9
10	Fire Panel	2008	2,675		10	856	856	1,391	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	TOTAL (lines 1 thru 33)		\$ 603,879	\$ 14,700		\$ 24,027	\$ 9,327	\$ 341,279	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 75,519	\$ 2,616	\$ 2,754	\$ 138	3-20 yrs	\$ 77,969	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 75,519	\$ 2,616	\$ 2,754	\$ 138		\$ 77,969	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	Program Tras (HSP)	2004 Chevy Express G150	2004	\$ 24,490	\$	\$	\$	4	\$ 24,490	76
77	Program Tras (BSP)	2003 Town & Country	2004	16,305	1,675		(1,675)	4	16,305	77
78	Program Tras (44th)	2004 Chevy Express	2004	21,046				4	21,046	78
79	Transportation	2008 Nissan Pathfinder	2007	55,585	8,756	9,221	465	4	40,218	79
80	TOTALS			\$ 117,426	\$ 10,431	\$ 9,221	\$ (1,210)		\$ 102,059	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)	\$ 902,831	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 27,747	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,002	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,255	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 568,314	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	1995 Pickup	\$ 47,007	\$	\$ 47,007	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 47,007	\$	\$ 47,007	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	TOTAL				\$ _____			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	TOTAL		\$ _____	\$ _____	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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. <u>CLASSROOM PORTION:</u></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>8</u></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)		1,914		1,914
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,914	\$	\$ 1,914
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,914		

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	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	23

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

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

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

	Service	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Beacon Street Place**# **0038729**Report Period Beginning: **01/01/09**

Ending:

12/31/09**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 33,163	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	372,419		3
4	Supply Inventory (priced at cost)	3,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,461		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 433,043	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	90,563		15
16	Equipment, at Historical Cost	239,951		16
17	Accumulated Depreciation (book methods)	(252,542)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 77,972	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 511,015	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 76,490	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	149,000		29
30	Accrued Salaries Payable	15,149		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,865		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,974		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,200		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 252,678	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 252,678	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 258,337	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 511,015	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 190,195	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 190,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	68,142	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 68,142	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 258,337	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place# 0038729Report Period Beginning: 01/01/09Ending: 12/31/09**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 984,437	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 984,437	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	171,578	9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,102	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 174,680	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,159,117	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	205,507	31
32	Health Care	494,659	32
33	General Administration	232,311	33
B. Capital Expense			
34	Ownership	103,283	34
C. Ancillary Expense			
35	Special Cost Centers	54,130	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,089,890	40
41	Income before Income Taxes (line 30 minus line 40)**	69,227	41
42	Income Taxes	(1,085)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 68,142	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

Facility Name & ID Number Beacon Street Place

0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	19,536	20,850	206,502	9.90
6	CNA Trainees	197	197	1,914	9.72
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	4,870	4,958	50,782	10.24
10	Activity Assistants	41	41	753	18.37
11	Social Service Workers	1,295	1,319	21,384	16.21
12	Dietician	697	697	11,161	16.01
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	780	780	13,540	17.36
18	Housekeepers	8,597	8,597	92,106	10.71
19	Laundry				19
20	Administrator	5,198	5,206	75,799	14.56
21	Assistant Administrator	390	390	7,020	18.00
22	Other Administrative				22
23	Office Manager	390	390	10,930	28.03
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	41,991	43,425	\$ 491,891 *	\$ 11.33

* 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	102	\$ 3,564	35
36	Medical Director	Fee	9,040	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	51	2,287	43
44	Activity Consultant			44
45	Social Service Consultant	Fee	620	45
46	Other(specify) <u>Psychologist</u>	Fee	3,600	46
47				47
48				48
49	TOTAL (lines 35 - 48)	153	\$ 19,111	49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place

0038729

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. No
- (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? N/A
- (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. _____
- (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. \$ 54,130
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? N/A
- (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. \$ 4,207 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? No
Firm Name: _____
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Autumn Leaves, Inc.
d/b/a Hickory Street Place, Beacon Stree Place, 44th Street Place
December 31, 2009

Documentation - Section V, Line 7, Column 3:

Waste Removal	1,202
Pest Control	635
Security	3,172
	5,009

Documentation - Section V, Line 15, Column 3:

Workshop	171,578
Emergency Dental Care	2,025
Drugs & Medicine	2,130
	175,733

Documentation - Section V, Line 30, Column 7:

Depreciation - Related Party	12,903
Straight-line adjustment	8,255
Central Office	1,330
	22,488

Reclassifications - Section V, Column 5:

	From Line #	To Line #	Amount
Employee Benefits (Staff Meals)	2	22	4,207

Page 7, Schedule VII, C, Related Parties
Column 5, Compensation Received from Other Homes

David Jacobus	
Drew Corporation	
d/b/a Moultrie County Community Center	
Decatur, Illinois	27,137

Section XVII, Reconciliation of Income to Taxable Income:

Net Income (Loss) Per Books	68,142
Additions:	
Federal Income Tax	-
Fines and Penalties	10,000
Deductions:	
Rounding	1
	78,143
Taxable Income	78,143

Section XX, General Information, Question 12:

Salary costs are allocated based upon actual hours worked.