

Facility Name & ID Number Galena Stauss Nursing Home

0049718 Report Period Beginning: 10/01/2008 Ending: 09/30/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,805</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,805</u>	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	Total		
8	SNF		<u>7,405</u>		<u>7,405</u>	8	
9	SNF/PED					9	
10	ICF	<u>11,598</u>			<u>11,598</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>11,598</u>	<u>7,405</u>		<u>19,003</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.34%

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 01/01/1970

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 09/30/2009

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

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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	191,874		87,372	279,246		279,246		279,246		1
2	Food Purchase		141,606		141,606		141,606		141,606		2
3	Housekeeping	47,826		7,759	55,585		55,585		55,585		3
4	Laundry			52,420	52,420		52,420		52,420		4
5	Heat and Other Utilities			41,844	41,844		41,844		41,844		5
6	Maintenance	26,184		15,099	41,283		41,283		41,283		6
7	Other (specify):*										7
8	TOTAL General Services	265,884	141,606	204,494	611,984		611,984		611,984		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,227,729		79,808	1,307,537		1,307,537		1,307,537		10
10a	Therapy										10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Incontinent Supplies		16,122		16,122		16,122		16,122		15
16	TOTAL Health Care and Programs	1,227,729	16,122	79,808	1,323,659		1,323,659		1,323,659		16
	C. General Administration										
17	Administrative	46,192		64,320	110,512		110,512		110,512		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	27,129		37,776	64,905		64,905		64,905		21
22	Employee Benefits & Payroll Taxes			296,744	296,744		296,744		296,744		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			20,559	20,559		20,559		20,559		26
27	Other (specify):*										27
28	TOTAL General Administration	73,321		419,399	492,720		492,720		492,720		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,566,934	157,728	703,701	2,428,363		2,428,363		2,428,363		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.

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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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			55,711	55,711	39,090	94,801		94,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					21,925	21,925	(1,787)	20,138			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* A&G Allocation			61,015	61,015	(61,015)						36
37	TOTAL Ownership			116,726	116,726		116,726	(1,787)	114,939			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			31,208	31,208		31,208		31,208			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			31,208	31,208		31,208		31,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,566,934	157,728	851,635	2,576,297		2,576,297	(1,787)	2,574,510			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				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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

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

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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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	2007 Bonds		X	Construction of New Hospital		10/01/06	\$ 45,485,000	\$ 45,485,000	10/1/2046	6.7500	\$ 20,138	1							
2				Administration is located in								2							
3				new facility - this portion								3							
4				relates to the NH's portion								4							
5				of the administrative offices.								5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 45,485,000	\$ 45,485,000			\$ 20,138	9							
B. Non-Facility Related*																			
10	Line of Credit Interest		X	Line of Credit for operations		2/1/08	500,000		2/1/09	5.5000	869	10							
11	Line of Credit Interest		X	Line of Credit for operations		7/1/08	500,000		7/1/09	5.5000	869	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$ 1,000,000	\$			\$ 1,738	14							
15	TOTALS (line 9+line14)						\$ 46,485,000	\$ 45,485,000			\$ 21,876	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.)

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

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,191 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Land. Row 2: 1. Row 3: 2. Row 4: 3 TOTALS

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	57	1962	1962	\$ 140,184	\$ 1,197	47	\$ 1,197		\$ 140,184
5			1971	172,403		41			172,403
6			1981	57,843	1,157	Various	1,157		56,879
7			1988	171,479	9,747	Various	9,747		97,272
8			2007	753,973	39,090	Various	39,090		67,075
Improvement Type**									
9	VARIOUS ADDITIONS	04/01/68		2,827	-	07 00			2,827
10	VAR. ADD.	04/01/69		63	-	07 00			63
11	VAR. ADD.	04/01/71		7,134	-	07 00			7,134
12	VAR. ADD.	04/01/72		229	-	15 00			229
13	VAR. ADD.	04/01/73		151	-	10 00			151
14	CURB.GUTTER&SDWLK-FRONT ENT	04/01/81		1,003	-	12 00			1,003
15	PARKING LOT EXPAN.	04/01/81		7,150	-	12 00			7,150
16	LANDSCAPING-HARMS	04/01/83		489	-	10 00			489
17	GRAVEL PARKING LOT	04/01/88		3,096	-	05 00			3,096
18	SIDEWALK	04/01/88		185	-	10 00			185
19	FENCE AROUND CHILLER	04/01/89		226	-	15 00			226
20	SIDEWALKS & CEMENT SLAB	04/01/89		801	-	15 00			801
21	CHAIN LINK FENCE	04/01/89		330	-	15 00			330
22	CONCRETE PARKING LOT	04/01/89		1,376	-	15 00			1,376
23	GAZEBO	04/01/89		1,282	-	15 00			1,282
24	SIDEWALKS-SPROULE	04/01/90		716	-	15 00			716
25	LANDSCAPING	03/31/04		1,209	121	10 00	121		665
26	CONCRETE DRIVEWAY	04/01/91		720	-	15 00			720
27	LANDSCAPING COURTYARD	04/01/91		1,261	-	10 00			1,261
28	PAVE PARKING LOT	04/01/94		1,902	-	12 00			1,902
29	PHYSICAL THERAPY/HELIO PAD	04/01/95		2,284	-	08 00			2,284
30	14 CAR BUMPERS	04/01/96		222	-	05 00			222
31	PARKING LOT	06/01/00		25,239	1,683	15 00	1,683		15,634
32	CEDAR PRIVACY FENCE	04/01/01		1,885	118	08 00	118		1,885
33	132 SHRUBS	03/01/02		1,421	-	05 00			1,421
34	LANDSCAPING	03/31/02		929	93	10 00	93		697
35	2 TREES	03/31/02		132	7	20 00	7		49
36	WOODEN FENCE AROUND HVAC	03/31/02		593	74	08 00	74		555

*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

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XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	MOVING/FLATING OF BACKFILL	03/31/02	\$ 1,704	\$ -	05 00			\$ 1,704	37
38	HANDICAP ENTRANCE	03/31/02	739	49	15 00	49		369	38
39	REPAIR TO SIDEWALK (CLINIC/NH)	03/31/02	1,136	76	15 00	76		568	39
40	MOVING/FLATTENING OF BACKFILL	11/29/02	373	-	05 00			373	40
41	TWO BRONZE PLAQUES	03/20/03	324	32	10 00	32		211	41
42	SHRUBS/LANDSCAPING/MULCHING	06/05/03	1,672	167	10 00	167		1,087	42
43	RESURFACE PARKING LOT	07/08/03	1,392	116	12 00	116		754	43
44	LANDSCAPING/SHRUBS/MULCH	07/23/03	406	41	10 00	41		264	44
45	PARKING LOT	07/25/05	2,848	356	08 00	356		1,602	45
46	LANDSCAPING & PARKING LOT	06/01/00	39,207	2,614	15 00	2,614		24,287	46
47	9 SHRUBS	03/31/02	98	-	05 00			98	47
48	2 TREES	03/31/02	75	4	20 00	4		28	48
49	LANDSCAPING	03/31/02	538	54	10 00	54		404	49
50	MULCH	03/31/02	64	6	10 00	6		48	50
51	BULLET EDGING	07/31/03	264	-	05 00			264	51
52	LANDSCAPING	07/31/03	1,185	119	10 00	119		771	52
53	SHRUBS	07/31/03	1,378	-	05 00			1,378	53
54	VARIOUS ADDITIONS	04/01/62	9,558	-	30 00			9,558	54
55	VAR. ADD.	04/01/69	471	-	20 00			471	55
56	STOREROOM	04/01/70	11,786	-	42 00			11,786	56
57	AIR CONDITIONING	04/01/70	5,137	-	20 00			5,137	57
58	AIR CONDITIONING	04/01/74	6,324	-	20 00			6,324	58
59	VARIOUS ADDITIONS	04/01/74	1,317	19	35 00	19		1,317	59
60	STOREROOM & MTC-GENERAL	04/01/75	35,867	522	34 00	522		35,867	60
61	STOREROOM & MTC-ELECTRICAL	04/01/75	3,825	-	20 00			3,825	61
62	STOREROOM & MTC-MECHANICAL	04/01/75	8,222	-	25 00			8,222	62
63	STOREROOM & MTC-SPRINKLER	04/01/75	1,481	-	25 00			1,481	63
64	VARIOUS ADDITIONS	04/01/75	111	-	25 00			111	64
65	ELECTRICAL 1975 ADDN	04/01/77	268	-	18 00			268	65
66	STORM WINDOWS & SCREENS-1962	04/01/77	1,031	16	32 00	16		1,031	66
67	REMODEL X-RAY ROOM	04/01/81	11,235	201	28 00	201		11,235	67
68	HEATING, VENTING, & AIR COND	04/01/82	1,150	-	08 00			1,150	68
69	INSULATION	04/01/82	5,661	-	15 00			5,661	69
70	TOTAL (lines 4 thru 69)		\$ 1,517,582	\$ 57,677		\$ 57,677	\$	\$ 725,816	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home

0049718

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,517,582	\$ 57,677		\$ 57,677	\$	\$ 725,816	1
2	ENCLOSED PORCH PATIO	04/01/82	2,975	-	15 00			2,975	2
3	RENOVATION OF C.S. AREA	04/01/83	1,067	-	20 00			1,067	3
4	LIGHT FIXTURES	04/01/84	529	-	10 00			529	4
5	VINYL WALL COVERING	04/01/84	3,975	-	10 00			3,975	5
6	224 CORRIDOR HANDRAIL	04/01/84	1,435	29	25 00	29		1,435	6
7	DIETARY REMODELING	04/01/84	1,384	28	25 00	28		1,384	7
8	MEDICAL RECORDS REMODELING	04/01/84	603	12	25 00	12		603	8
9	ELECTRICAL WORK	04/01/85	275	-	20 00			275	9
10	REMOTE THERMOSTATS	04/01/85	1,587	-	20 00			1,587	10
11	WALL COVERINGS	04/01/85	3,769	-	10 00			3,769	11
12	GENERAL CONTRACT	04/01/85	32,280	672	24 00	672		32,280	12
13	ELECTRICAL	04/01/85	19,623	-	20 00			19,623	13
14	MECHANICAL	04/01/85	29,728	-	20 00			29,728	14
15	MILLWORK	04/01/85	11,687	-	20 00			11,687	15
16	FLOORING	04/01/85	3,847	-	05 00			3,847	16
17	PAINTING	04/01/85	6,443	-	05 00			6,443	17
18	NEW ROOM-GIESE	04/01/86	11,426	-	10 00			11,426	18
19	REMODELING-NURSERY	04/01/86	223	-	10 00			223	19
20	PAINTING-TIEGS	04/01/87	1,551	-	05 00			1,551	20
21	12-NEW WINDOWS-GREENCO	04/01/87	3,873	-	12 00			3,873	21
22	ROOF REPLACEMENT	04/01/88	1,090	-	10 00			1,090	22
23	REMODELING-OLD N.H.	04/01/88	1,308	-	20 00			1,308	23
24	FLOOR COVERINGS-BLDG ADD'N	05/01/88	3,859	-	10 00			3,859	24
25	PAINTING-BLDG ADD'N	05/01/88	7,644	-	05 00			7,644	25
26	MILLWORK-BLDG ADD'N	05/01/88	5,952	-	20 00			5,927	26
27	PLUMBING-BLDG ADD'N	05/01/88	24,989	-	20 00			24,885	27
28	HEATING & A/C-BLDG ADD'N	05/01/88	24,437	-	20 00			24,335	28
29	ELECTRICAL-BLDG ADD'N	05/01/88	29,352	-	20 00			29,230	29
30	FIRE ALARM SYSTEM	04/01/89	9,342	-	15 00			9,342	30
31	AIR CONDITIONING REPLACEMENT	04/01/89	8,507	-	10 00			8,507	31
32	BOILER REPLACEMENT	04/01/89	21,148	529	20 00	529		21,148	32
33	INSULATION	04/01/90	948	-	10 00			948	33
34	TOTAL (lines 1 thru 33)		\$ 1,794,437	\$ 58,946		\$ 58,946	\$	\$ 1,002,319	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home

0049718

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,794,437	\$ 58,946		\$ 58,946	\$	\$ 1,002,319	1
2	NEW DOORS-GREENCO	04/01/90	2,740	-	15 00			2,740	2
3	PAINTING-STRUB	04/01/90	601	-	05 00			601	3
4	DOOR ALARM SYSTEM	04/01/91	750	-	15 00			750	4
5	REMODELING-N.H.	04/01/92	536	-	10 00			536	5
6	GARAGE DOOR	04/01/92	513	-	10 00			513	6
7	REMODELING-N.H.	04/01/94	2,881	144	20 00	144		2,233	7
8	NEW ROOF-GIESE	04/01/94	2,767	-	10 00			2,767	8
9	NEW ROOF	04/01/96	20,693	-	10 00			20,693	9
10	DRAIN LINE UNDER FLOOR	04/01/96	1,819	-	10 00			1,819	10
11	ELECTRICAL-RADIOLOGY REMODEL	04/01/96	13,501	750	18 00	750		10,126	11
12	GENERAL-RADIOLOGY REMODELING	04/01/96	31,215	1,561	20 00	1,561		21,070	12
13	HELIPORT LIGHTING	04/01/96	1,511	101	15 00	101		1,360	13
14	ROOF IMPROVEMENT	04/01/97	856	-	10 00			856	14
15	PHYSICAL THERAPY ROOM REMODEL	04/01/97	4,169	208	20 00	208		2,606	15
16	HEATING AND A/C UNITS	04/01/99	1,649	82	10 00	82		1,649	16
17	2 STANLEY MAGIC AUTOMATIC DOORS	04/01/99	1,221	61	10 00	61		1,221	17
18	REBUILD CHILLER	04/01/99	3,665	183	10 00	183		3,665	18
19	FIRE ALARM IMPROVEMENTS	04/01/00	1,376	138	10 00	138		1,307	19
20	ARMSTRONG TILE FLOORING FOR DIETARY	04/01/00	1,287	64	20 00	64		611	20
21	FIRE ALARM SYSTEM-ADMINISTRATION	04/01/01	905	60	15 00	60		513	21
22	REMODELING-BUSINESS OFFICE	04/01/01	63,451	4,230	15 00	4,230		35,955	22
23	HOOD & EXHAUST WORK - DIETARY	04/01/01	906	45	20 00	45		385	23
24	RADIOLOGY REMODEL	03/31/02	23,995	1,600	15 00	1,600		11,997	24
25	NURSING HOME NEW CEILING	03/31/02	2,788	279	10 00	279		2,091	25
26	NURSING HOME SHOWER FLOORS	03/31/02	471	24	20 00	24		177	26
27	CARPET-HALLWAY	03/31/02	5,451	-	05 00			5,451	27
28	NURSING HOME REMODEL	11/04/02	3,088	309	10 00	309		2,007	28
29	NURSING HOME CARPET	11/20/02	4,742	-	05 00			4,742	29
30	NURSING HOME THERMOSTATS & ELECTRIC	01/09/03	2,428	243	10 00	243		1,578	30
31	AUTOMATIC ENTRANCE MED-SURG	01/28/03	7,501	-	05 00			7,501	31
32	ADMINISTRATION REMODEL	03/26/03	5,490	366	15 00	366		2,379	32
33	NURSING HOME FIRE DOOR	03/31/03	1,310	131	10 00	131		851	33
34	TOTAL (lines 1 thru 33)		\$ 2,010,717	\$ 69,526		\$ 69,526	\$	\$ 1,155,073	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home

0049718

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,010,717	\$ 69,526		\$ 69,526	\$	\$ 1,155,073	1
2	HOSPITAL GENERATOR POWER SOURCE	03/31/03	4,990	-	05 00			4,990	2
3	ELECTRICAL WORK	10/31/03	3,736	187	20 00	187		1,027	3
4	WATER HEATERS	10/31/03	844	84	10 00	84		464	4
5	FLOORING	10/31/03	927	93	05 00	93		927	5
6	DENSITOMETER ROOM	03/31/04	4,102	410	05 00	410		4,102	6
7	CIRCULATING BOOSTER PUMP	04/30/04	2,708	271	10 00	271		1,490	7
8	PT REMODEL	05/01/04	8,044	536	15 00	536		2,949	8
9	AUTOMATIC DOOR	07/01/04	778	78	10 00	78		428	9
10	CT REMODEL	05/20/05	58,450	2,922	20 00	2,922		13,151	10
11	CARPET-EDUCATION ROOM	07/19/05	464	93	05 00	93		417	11
12	WOOD FLOORING-DINING ROOMS	07/19/05	781	78	10 00	78		352	12
13	MAMMOGRAM ROOM REMODEL	08/30/05	3,430	229	15 00	229		1,029	13
14	REMODELING-GENERAL	04/01/94	52,850	1,957	27 00	1,957		30,340	14
15	PLUMBING	04/01/94	4,680	234	20 00	234		3,627	15
16	HEATING,VENTING,AIR COND.	04/01/94	11,049	552	20 00	552		8,563	16
17	ELECTRICAL	04/01/94	21,537	1,077	20 00	1,077		16,691	17
18	PAINTING	04/01/94	650	-	10 00			650	18
19	SUSPENDED CEILING	04/01/94	2,919	-	12 00			2,919	19
20	CABINETS	04/01/94	7,332	367	20 00	367		5,682	20
21	FLOOR COVERINGS	04/01/94	4,840	-	10 00			4,840	21
22	ELEVATOR	04/01/94	11,876	594	20 00	594		9,204	22
23	HAND RAIL FOR PHYSICAL THERAPY	12/17/02	303	20	15 00	20		131	23
24	EXTENSION JOINT	11/03/04	530	106	05 00	106		477	24
25	ELEVATOR PROCESSOR BOARD	12/01/05	981	196	05 00	196		744	25
26	ER REMODEL/SHOWER ROOM	01/01/06	1,671	111	15 00	111		413	26
27	GARAGE DOOR	07/01/06	436	44	10 00	44		140	27
28	FLOORING	09/22/06	233	23	10 00	23		81	28
29	HEATING	09/30/07	2,126	142	15 00	142		354	29
30	SPRINKLER SYSTEM	09/30/07	22,633	905	25 00	905		2,263	30
31	SPRINKLER SYSTEM	09/30/07	2,220	89	25 00	89		222	31
32	HVAC UNIT	09/30/07	7,044	470	15 00	470		1,174	32
33	PLASTIC CULVERT PIPE	09/30/07	1,470	73	20 00	73		184	33
34	TOTAL (lines 1 thru 33)		\$ 2,257,350	\$ 81,467		\$ 81,467	\$	\$ 1,275,100	34

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,257,350	\$ 81,467		\$ 81,467	\$	\$ 1,275,100	1
2	Building Components/Remodeling - 2007 Nursing Home	12/05/07	1,380	69	20 00	69	127	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,258,731	\$ 81,536		\$ 81,536	\$	\$ 1,275,227	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Nursing Home

0049718

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

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	\$ 75,989	\$ 13,195	\$ 13,195	\$	various	\$ 55,136	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	60,963	2,108	2,108		various	60,693	73
74								74
75	TOTALS	\$ 136,952	\$ 15,303	\$ 15,303	\$		\$ 115,829	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,395,683	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,839	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,839	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,391,056	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

- (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 Galena Stauss Nursing Home# 0049718Report Period Beginning: 10/01/2008Ending: 09/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 328,939	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>990,000</u>)	2,476,512		3
4	Supply Inventory (priced at <u>Cost</u>)	249,357		4
5	Short-Term Investments	1,535,119		5
6	Prepaid Insurance	90,545		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)	\$ 4,680,472	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,127,337		12
13	Land	559,916		13
14	Buildings, at Historical Cost	42,582,692		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	9,435,358		16
17	Accumulated Depreciation (book methods)	(12,102,030)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,058		21
22	Other Long-Term Assets (spe <u>Intangible Asset</u>)	21,976		22
23	Other(specify): <u>Bond Issuance Costs</u>	890,610		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 47,519,917	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 52,200,389	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 673,609	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	53,444		29
30	Accrued Salaries Payable	471,652		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,535,119		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Deferred Revenue</u>	87,591		36
37	<u>Amounts payable to Medicare</u>	639,434		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,460,849	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	45,485,000		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)	\$ 45,485,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,945,849	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,254,540	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 52,200,389	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,572,609	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,572,609	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,322,009)	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) Temp Restricted Contributions	20,814	15
16	Other (describe) Loans forgiven from Temp Restricted Net Asse	(16,874)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (5,318,069)	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)	\$ 3,254,540	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home# 0049718Report Period Beginning: 10/01/2008Ending: 09/30/2009

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	\$ 3,252,279	1
2	Discounts and Allowances for all Levels	(913,618)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,338,661	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		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	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)	\$ 2,338,661	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	611,984	31
32	Health Care	1,323,659	32
33	General Administration	492,720	33
B. Capital Expense			
34	Ownership	116,726	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	31,208	36
D. Other Expenses (specify):			
37	Hospital Net Loss	5,084,373	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,660,670	40
41	Income before Income Taxes (line 30 minus line 40)**	(5,322,009)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,322,009)	43

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

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

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

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

Facility Name & ID Number **Galena Stauss Nursing Home**

0049718

Report Period Beginning: **10/01/2008**

Ending:

09/30/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,081	2,075	\$ 63,655	\$ 30.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,987	7,965	188,709	23.69	3
4	Licensed Practical Nurses	8,849	8,825	172,987	19.60	4
5	CNAs & Orderlies	48,207	48,077	583,712	12.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,594	3,585	31,574	8.81	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,968	1,963	61,560	31.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	1,959	1,954	22,221	11.37	33
34	TOTAL (lines 1 - 33)	74,645	74,444	\$ 1,124,418 *	\$ 15.10	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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 Galena Stauss Nursing Home

0049718

Report Period Beginning: 10/01/2008

Ending: 09/30/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? None added
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,122 Line 15
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,208
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Wipfli LLP
- (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