

Facility Name & ID Number Ninth Street Place

0038505 Report Period Beginning: 7/1/08 Ending: 6/30/09

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 16

	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	<u>5840</u>	Intermediate (ICF)	<u>16</u>	<u>5,840</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>5840</u>	TOTALS	<u>16</u>	<u>5,840</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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>5,734</u>			<u>5,734</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,734</u>			<u>5,734</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.18%

D. How many bed-hold days during this year were paid by the Department? 106 (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 2/5/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/5/93 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 No

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Ninth Street Place # 0038505 Report Period Beginning: 7/1/08 Ending: 6/30/09

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		1,462	1,834	3,296		3,296		3,296		1
2	Food Purchase		33,929		33,929	(3,560)	30,369	67	30,436		2
3	Housekeeping		5,097	957	6,054		6,054	537	6,591		3
4	Laundry										4
5	Heat and Other Utilities			16,051	16,051		16,051	264	16,315		5
6	Maintenance		14,146	1,563	15,709		15,709	877	16,586		6
7	Other (specify):*										7
8	TOTAL General Services		54,634	20,405	75,039	(3,560)	71,479	1,745	73,224		8
	B. Health Care and Programs										
9	Medical Director			2,750	2,750		2,750		2,750		9
10	Nursing and Medical Records	328,915	12,094	80	341,089		341,089	571	341,660		10
10a	Therapy										10a
11	Activities		1,477		1,477		1,477		1,477		11
12	Social Services	13,508			13,508		13,508		13,508		12
13	CNA Training	14,020	125		14,145		14,145		14,145		13
14	Program Transportation		3,872		3,872		3,872		3,872		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	356,443	17,568	2,830	376,841		376,841	571	377,412		16
	C. General Administration										
17	Administrative	62,634			62,634		62,634	35,349	97,983		17
18	Directors Fees										18
19	Professional Services							1,275	1,275		19
20	Dues, Fees, Subscriptions & Promotions			2,568	2,568		2,568	2,453	5,021		20
21	Clerical & General Office Expenses		1,058	4,774	5,832		5,832	1,730	7,562		21
22	Employee Benefits & Payroll Taxes			77,727	77,727	3,560	81,287	7,802	89,089		22
23	Inservice Training & Education							90	90		23
24	Travel and Seminar			181	181		181	154	335		24
25	Other Admin. Staff Transportation		2,027	216	2,243		2,243	354	2,597		25
26	Insurance-Prop.Liab.Malpractice							467	467		26
27	Other (specify):*										27
28	TOTAL General Administration	62,634	3,085	85,466	151,185	3,560	154,745	49,674	204,419		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	419,077	75,287	108,701	603,065		603,065	51,990	655,055		29

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

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

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			20,553	20,553		20,553	1,943	22,496			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							214	214			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			20,553	20,553		20,553	2,157	22,710			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			35,333	35,333		35,333		35,333			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,333	35,333		35,333		35,333			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	419,077	75,287	164,587	658,951		658,951	54,147	713,098			45

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

Ninth Street Place

ID# 0038505

Report Period Beginning: 7/1/08

Ending: 6/30/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ninth Street Place# 0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	67	0	0	0	0	0	0	0	0	0	67	2
3	Housekeeping	0	537	0	0	0	0	0	0	0	0	0	537	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	264	0	0	0	0	0	0	0	0	0	264	5
6	Maintenance	0	877	0	0	0	0	0	0	0	0	0	877	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,745	0	0	0	0	0	0	0	0	0	1,745	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	571	0	0	0	0	0	0	0	0	0	571	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	571	0	0	0	0	0	0	0	0	0	571	16
	C. General Administration													
17	Administrative	0	35,349	0	0	0	0	0	0	0	0	0	35,349	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,275	0	0	0	0	0	0	0	0	0	1,275	19
20	Fees, Subscriptions & Promotions	0	2,453	0	0	0	0	0	0	0	0	0	2,453	20
21	Clerical & General Office Expenses	0	1,730	0	0	0	0	0	0	0	0	0	1,730	21
22	Employee Benefits & Payroll Taxes	0	7,802	0	0	0	0	0	0	0	0	0	7,802	22
23	Inservice Training & Education	0	90	0	0	0	0	0	0	0	0	0	90	23
24	Travel and Seminar	0	0	154	0	0	0	0	0	0	0	0	154	24
25	Other Admin. Staff Transportation	0	0	354	0	0	0	0	0	0	0	0	354	25
26	Insurance-Prop.Liab.Malpractice	0	0	467	0	0	0	0	0	0	0	0	467	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	48,699	975	0	0	0	0	0	0	0	0	49,674	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	51,015	975	0	0	0	0	0	0	0	0	51,990	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ninth Street Place# 0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	0	0	1,943	0	0	0	0	0	0	0	0	1,943	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	214	0	0	0	0	0	0	0	0	214	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	2,157	0	2,157	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)	0	51,015	3,132	0	0	0	0	0	0	0	0	54,147	45

Facility Name & ID Number

Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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
None						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	2 Food and Beverage	\$	ARC/RIC	100.00%	\$ 67	\$	67 1
2	V	3 Housekeeping		ARC/RIC	100.00%	537		537 2
3	V	5 Utilities		ARC/RIC	100.00%	264		264 3
4	V	6 Maintenance		ARC/RIC	100.00%	877		877 4
5	V	19 Account/Consult		ARC/RIC	100.00%	1,037		1,037 5
6	V	19 Legal Fees		ARC/RIC	100.00%	238		238 6
7	V	17 Administration Salaries		ARC/RIC	100.00%	35,349		35,349 7
8	V	20 Sub/Promotion/Printing		ARC/RIC	100.00%	2,453		2,453 8
9	V	21 Office Supplies		ARC/RIC	100.00%	1,534		1,534 9
10	V	21 Telephone		ARC/RIC	100.00%	196		196 10
11	V	22 Employee Benefits		ARC/RIC	100.00%	7,802		7,802 11
12	V	10 Medical/Hygiene Supplies		ARC/RIC	100.00%	571		571 12
13	V	23 Staff Training		ARC/RIC	100.00%	90		90 13
14	Total		\$			\$ 51,015	\$ *	51,015 14

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning: 7/1/08

Ending: 6/30/09

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	24 Travel Seminar	\$	ARCRIC	100.00%	\$ 154	\$	154	15
16	V	25 Other Administration, Staff Transportation		ARCRIC	100.00%	354		354	16
17	V	26 Insurance/Prof/Liability		ARCRIC	100.00%	467		467	17
18	V	32 Interest Mortgage		ARCRIC	100.00%	214		214	18
19	V	30 Depreciation		ARCRIC	100.00%	1,943		1,943	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 3,132	\$ *	3,132	39

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

Facility Name & ID Number

Ninth Street Place

#

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	None								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending: 6/30/09

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 Association for Retarded Citizens
 Street Address 4016 9th Street
 City / State / Zip Code Rock Island IL 61201
 Phone Number (309-786-6474
 Fax Number (309-786-9861

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	2	Food and Beverage	Total percentage of budgeted	17 programs	\$ 1,200	\$	65,363	\$ 67	1
2	3	Housekeeping	Administrative costs are	17 programs	9,577		65,363	537	2
3	5	Utilities	to be allocated based on	17 programs	4,709		65,363	264	3
4	6	Maintenance	percentage of salary	17 programs	15,634		65,363	877	4
5	19	Accountant/Consultant		17 programs	18,490		65,363	1,037	5
6	19	Legal Fees		17 programs	4,244		65,363	238	6
7	17	Administration Salaries		17 programs	630,101		65,363	35,349	7
8	20	Sub/Promotion/Printing		17 programs	43,731		65,363	2,453	8
9	21	Office Expense		17 programs	27,339		65,363	1,534	9
10	21	Telephone		17 programs	3,487		65,363	196	10
11	22	Employer Benefits		17 programs	139,065		65,363	7,802	11
12	10	Medical/Hygiene Supplies		17 programs	10,186		65,363	571	12
13	23	Staff Training		17 programs	1,608		65,363	90	13
14	24	Travel Seminar		17 programs	2,748		65,363	154	14
15	25	Other Administration, Staff Transportation		17 programs	6,313		65,363	354	15
16	26	Insurance/Prof/Liability		17 programs	8,331		65,363	467	16
17	30	Interest Mortgage		17 programs	3,820		65,363	214	17
18	30	Depreciation		17 programs	34,639		65,363	1,943	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 965,222	\$		\$ 54,147	25

Facility Name & ID Number

Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	None					\$	\$			\$								
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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

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

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,218 B. General Construction Type: Exterior Vinyl Siding Frame Wood Frame Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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: None 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>DD Facility</u>	<u>99,015</u>	<u>1997</u>	<u>\$ 25,155</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	99,015		\$ 25,155	3

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1997	1992	\$ 417,394	\$ 13,251	31.5	\$ 13,251	\$	\$ 152,926
5									
6									
7									
8									
	Improvement Type**								
9	Insulation		1994	4,038		31.5			
10	Final Payment on Retainage Building Fee		1995	1,051		31.5			
11	Engineering and Architecture		1993	16,791		31.5			
12	Dumpster Enclosure		1994	550	17	31.5	17		266
13	Vinyl Floor		1995	875	28	31.5	28		377
14	Carpet/Gazebo		1997	5,126	163	31.5	163		2,038
15	Fence		1997	2,936	93	31.5	93		1,070
16	Carpet/Gazebo		1998	1,690	54	31.5	54		588
17	Wall Protection		1998	1,044	33	31.5	33		380
18	Paved Parking Lot		1998	1,600	51	31.5	51		586
19	Vinyl Floor		1999	3,300	106	31.5	106		954
20	Sidewalk Concrete		2000	3,000	95	31.5	95		904
21	Automatic Doors		2000	2,253	72	31.5	72		612
22	Sidewalk Handrails		2000	2,706	86	31.5	86		731
23	Toilet Toppers		2000	852	27	31.5	27		230
24	Interior Handrail		2001	596	19	31.5	19		142
25	Vinyl Floor/Tile in Tub Room		2001	1,024	33	31.5	33		214
26	Install Interior Handrails		2002	910	29	31.5	29		188
27	Vinyl Flooring		2003	1,745	55	31.5	55		303
28	Install Vinyl Flooring		2005	1,745	55	31.5	55		248
29	Kitchen Cabinets		2005	1,755	56	31.5	56		252
30	Install Bathroom Tiles		2005	3,280	104	31.5	104		468
31	Install Whirlpool tub		2005	2,951	94	31.5	94		423
32	Install Kitchen Cabinets		2006	675	21	31.5	21		74
33	Install Ceramic Tile Floor in Kitchen		2006	4,392	139	31.5	139		487
34	New Window Blinds/Installation		2006	880	28	31.5	28		98
35	Concrete Sidewalks		2006	3,800	121	31.5	121		423
36	Repair Fire Sprinkler System		2006	1,463	46	31.5	46		161

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Install New Fence	2007	\$ 2,321	\$ 74	31.5	\$ 74	\$ 185	37
38	Clean Air Ducts	2007	980	31	31.5	31	78	38
39	Retile 2 Bedrooms	2007	2,000	63	31.5	63	158	39
40	Install Air Conditioning Unit	2008	1,100	35	31.5	35	52	40
41	Install 3 New Windows	2008	500	16	31.5	16	24	41
42	Install Generator	2009	15,400	244	31.5	244	244	42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 512,723	\$ 15,339		\$ 15,339	\$ 165,884	70

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	\$ 76,350	\$ 5,458	\$ 5,458	\$	10	\$	71
72	Current Year Purchases	2,296	230	230		10	230	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 78,646	\$ 5,688	\$ 5,688	\$		\$ 230	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	Patient Care	2006 Ford Freestar Van	2006	\$ 9,068	\$ 1,814	\$ 1,814	\$	5	\$ 5,441	76
77										77
78										78
79										79
80	TOTALS			\$ 9,068	\$ 1,814	\$ 1,814	\$		\$ 5,441	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)	\$ 625,592	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,841	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,841	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)	\$ 171,555	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 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>60</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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	25	100		125
3	Classroom Wages (a)	425	2,128		2,553
4	Clinical Wages (b)	567	2,836		3,403
5	In-House Trainer Wages (c)	1,344	6,720		8,064
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 2,361	\$ 11,784	\$	\$ 14,145
10	SUM OF line 9, col. 1 and 2 (e)	\$ 14,145			

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	5

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning: 7/1/08

Ending: 6/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/09 (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	\$ 65,511	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	240,424		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	604		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 306,539	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,155		13
14	Buildings, at Historical Cost	512,723		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	87,714		16
17	Accumulated Depreciation (book methods)	(171,555)		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)	\$ 454,037	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 760,576	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 24,595	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,503		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 109,098	\$	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)	\$ 109,098	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 651,478	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 760,576	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 585,574	1
2	Restatements (describe):		2
3	Reclassification of Fixed Assets	41,170	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 626,744	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	24,734	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)	\$ 24,734	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)	\$ 651,478	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Ninth Street Place# 0038505Report Period Beginning: 7/1/08Ending: 6/30/09

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	\$ 664,921	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 664,921	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	83	9
10	Other Government Grants	1,414	10
11	CNA Training Reimbursements	9,479	11
12	Gift and Coffee Shop	1	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	905	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	3,329	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,211	23
D. Non-Operating Revenue			
24	Contributions	2,237	24
25	Interest and Other Investment Income***	1,316	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,553	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)	\$ 683,685	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	75,039	31
32	Health Care	376,841	32
33	General Administration	151,185	33
B. Capital Expense			
34	Ownership	20,553	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	35,333	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 658,951	40
41	Income before Income Taxes (line 30 minus line 40)**	24,734	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 24,734	43

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

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

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

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	2,995	49,817	16.63	4
5	CNAs & Orderlies				5
6	CNA Trainees	545	5,956	10.93	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				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	838	25,892	30.90	20
21	Assistant Administrator	2,080	36,742	17.66	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction	470	8,064	17.16	26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	915	13,508	14.76	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	25,535	279,098	10.93	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	33,378	\$ 419,077 *	\$ 12.56	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	45	\$ 1,834	L1C3 35
36	Medical Director	Annual	2,750	L9C3 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant		80	L10c3 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)	45	\$ 4,664	49

C. CONTRACT NURSES

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

Facility Name & ID Number Ninth Street Place

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jane O'Melia	Administrator		\$ 25,892	Workers' Compensation Insurance	\$ 11,821	IDPH License Fee	\$ 250	
Mark Cummings	Supervisor		36,742	Unemployment Compensation Insurance		Advertising: Employee Recruitment	987	
				FICA Taxes	32,123	Health Care Worker Background Check		
				Employee Health Insurance	16,915	(Indicate # of checks performed)		
				Employee Meals	3,560	Patient Background Checks	5 0	
				Illinois Municipal Retirement Fund (IMRF)*		Staff Award and Recognition	546	
				Pension Expense Employer Paid	16,320	Arc of IL dues and US Dues	1,674	
				Disability Insurance	101	Subscriptions	25	
				Group Term	440	Direct Deposit Fees	205	
				Admin Fringe Benefits from schedule VIII line 11 c9	7,802	Carf Certification	1,334	
				Immunizations Costs	7	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 62,634	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,021
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
							Out-of-State Travel	
							In-State Travel	
							335	
							Seminar Expense	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 335	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Ninth Street Place# 0038505Report Period Beginning: 7/1/08Ending: 6/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None 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. \$ 35,333
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. \$ 3,560 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?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey and Pullen, 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.