

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0037036</u></p> <p>Facility Name: <u>Pilot House</u></p> <p>Address: <u>1111 Washington Avenue, Box 369</u> <u>Cairo</u> <u>62914</u> Number City Zip Code</p> <p>County: <u>Alexander</u></p> <p>Telephone Number: <u>(618)734-3706</u> Fax # <u>(618)833-4993</u></p> <p>HFS ID Number: <u>37-1272696001</u></p> <p>Date of Initial License for Current Owners: <u>8/25/1988</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ashley Alley</u> Telephone Number: <u>(618) 833-5070 x11</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Ashley Alley</u> (Title) <u>Asst. Comptroller</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Ashley Alley</u> (Title) <u>Asst. Comptroller</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.	_____																											
	<input type="checkbox"/> Limited Liability Co.	_____																											
	<input type="checkbox"/> Trust	_____																											
	<input type="checkbox"/> Other	_____																											
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Ashley Alley</u> (Title) <u>Asst. Comptroller</u>																												
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____																												

Facility Name & ID Number Pilot House

0037036 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5856

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less	16	5,856	6
7		TOTALS	16	5,856	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					11
12	SC					12
13	DD 16 OR LESS	5,777			5,777	13
14	TOTALS	5,777			5,777	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.65%

D. How many bed-hold days during this year were paid by the Department? 66 (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 1/1/1991

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/1/1991 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Pilot House # 0037036 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		4,459	1,529	5,988		5,988	0	5,988		1
2	Food Purchase		54,350		54,350		54,350	0	54,350		2
3	Housekeeping	22,123	4,353		26,476		26,476	87	26,563		3
4	Laundry		1,007		1,007	0	1,007	0	1,007		4
5	Heat and Other Utilities			17,422	17,422		17,422	223	17,645		5
6	Maintenance		2,987	3,764	6,751		6,751	4,299	11,050		6
7	Other (specify):*				0		0	0	0		7
8	TOTAL General Services	22,123	67,156	22,715	111,994	0	111,994	4,609	116,603		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600	0	3,600		9
10	Nursing and Medical Records	165,163	2,342	11,829	179,334		179,334	973	180,307		10
10a	Therapy			3,280	3,280		3,280	0	3,280		10a
11	Activities	25,325	1,077	198	26,600		26,600	0	26,600		11
12	Social Services		3,897	1,025	4,922		4,922	(646)	4,276		12
13	CNA Training				0		0	0	0		13
14	Program Transportation		3,076	4,300	7,376		7,376	515	7,891		14
15	Other (specify):* Day Training			115,720	115,720		115,720	(115,720)	0		15
16	TOTAL Health Care and Programs	190,488	10,392	139,952	340,832	0	340,832	(114,878)	225,954		16
	C. General Administration										
17	Administrative	24,018		6,000	30,018		30,018	4,698	34,716		17
18	Directors Fees			2,000	2,000		2,000	80	2,080		18
19	Professional Services			25,230	25,230		25,230	(23,913)	1,317		19
20	Dues, Fees, Subscriptions & Promotions			1,837	1,837		1,837	(106)	1,731		20
21	Clerical & General Office Expenses		1,774	3,959	5,733		5,733	8,291	14,024		21
22	Employee Benefits & Payroll Taxes			37,218	37,218		37,218	3,120	40,338		22
23	Inservice Training & Education			21	21		21	0	21		23
24	Travel and Seminar				0		0	0	0		24
25	Other Admin. Staff Transportation				0		0	0	0		25
26	Insurance-Prop.Liab.Malpractice			2,812	2,812		2,812	302	3,114		26
27	Other (specify):*				0		0	0	0		27
28	TOTAL General Administration	24,018	1,774	79,077	104,869	0	104,869	(7,528)	97,341		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	236,629	79,322	241,744	557,695	0	557,695	(117,797)	439,898		29

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

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

Facility Name & ID Number Pilot House

#0037036

Report Period Beginning:

1/1/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,696	4,696		4,696	14,213	18,909			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes			9,132	9,132		9,132	135	9,267			33
34	Rent-Facility & Grounds			38,400	38,400		38,400	(37,922)	478			34
35	Rent-Equipment & Vehicles				0		0	174	174			35
36	Other (specify):* See Pg. 25			40,939	40,939		40,939	(40,939)	0			36
37	TOTAL Ownership			93,167	93,167	0	93,167	(64,339)	28,828			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			31,485	31,485		31,485	0	31,485			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	31,485	31,485	0	31,485	0	31,485			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	236,629	79,322	366,396	682,347	0	682,347	(182,136)	500,211			45

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

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	\$ (115,720)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(195)	22		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	13,992	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(66)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(40,939)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(723)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (143,651)		\$ 0	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)	(38,485)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,485)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (182,136)		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

Pilot House

ID# 0037036

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Personal Items	\$ (646)	12	1
2	PAC Dues	(77)	20	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
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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	(723)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pilot House# 0037036

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	87	0	0	0	0	0	0	0	0	0	87	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	223	0	0	0	0	0	0	0	0	0	223	5
6	Maintenance	0	114	4,185	0	0	0	0	0	0	0	0	4,299	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	424	4,185	0	4,609	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	0	973	0	0	0	0	0	0	0	0	973	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	(646)	0	0	0	0	0	0	0	0	0	0	(646)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	515	0	0	0	0	0	0	0	0	0	515	14
15	Other (specify):*	(115,720)	0	0	0	0	0	0	0	0	0	0	(115,720)	15
16	TOTAL Health Care and Programs	(116,366)	515	973	0	(114,878)	16							
	C. General Administration													
17	Administrative	0	0	4,698	0	0	0	0	0	0	0	0	4,698	17
18	Directors Fees	0	80	0	0	0	0	0	0	0	0	0	80	18
19	Professional Services	0	87	(24,000)	0	0	0	0	0	0	0	0	(23,913)	19
20	Fees, Subscriptions & Promotions	(143)	37	0	0	0	0	0	0	0	0	0	(106)	20
21	Clerical & General Office Expenses	0	1,033	7,258	0	0	0	0	0	0	0	0	8,291	21
22	Employee Benefits & Payroll Taxes	(195)	3,315	0	0	0	0	0	0	0	0	0	3,120	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	302	0	0	0	0	0	0	0	0	0	302	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(338)	4,854	(12,044)	0	(7,528)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(116,704)	5,793	(6,886)	0	(117,797)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pilot House# 0037036

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	13,992	221	0	0	0	0	0	0	0	0	0	14,213	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	135	0	0	0	0	0	0	0	0	0	135	33
34	Rent-Facility & Grounds	0	478	(38,400)	0	0	0	0	0	0	0	0	(37,922)	34
35	Rent-Equipment & Vehicles	0	0	174	0	0	0	0	0	0	0	0	174	35
36	Other (specify):*	(40,939)	0	0	0	0	0	0	0	0	0	0	(40,939)	36
37	TOTAL Ownership	(26,947)	834	(38,226)	0	(64,339)	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)	(143,651)	6,627	(45,112)	0	0	0	0	0	0	0	0	(182,136)	45

Facility Name & ID Number Pilot House

0037036

Report Period Beginning:

1/1/09

Ending:

12/31/09

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Mulberry Manor	Anna	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
JoAnn Keller	50	Holly Hill	Anna	JR's Centre	Anna	Workshop
James K. Keller	50	Lincoln Square	Jonesboro	ILS 1-3 & 5-6	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis	ILS Land Trust	Anna	Land Trust
		New Way	Anna	J & J Partner's	Anna	Land Trust
		Liberty House	Marion			

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)		
1	V	3 House keeping	\$	kel-Tech Management Co.	25.00%	\$ 87	\$	87	1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	223		223	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	114		114	3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	515		515	4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	80		80	5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	87		87	6
7	V	20 Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	37		37	7
8	V	21 Clerical & General		kel-Tech Management Co.	25.00%	1,033		1,033	8
9	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	3,315		3,315	9
10	V	26 Insurance		kel-Tech Management Co.	25.00%	302		302	10
11	V	30 Depreciation		kel-Tech Management Co.	25.00%	221		221	11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	135		135	12
13	V	34 Rent		kel-Tech Management Co.	25.00%	478		478	13
14	Total		\$			\$ 6,627	\$ *	6,627	14

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

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	35 Equipment Rental	\$	kel-Tech Management Co.	25.00%	\$ 174	\$	174	15
16	V	10 Nursing		kel-Tech Management Co.	25.00%	973		973	16
17	V	17 Administration		kel-Tech Management Co.	25.00%	4,698		4,698	17
18	V	21 Clerical		kel-Tech Management Co.	25.00%	7,258		7,258	18
19	V	6 Maintenance		kel-Tech Management Co.	25.00%	4,185		4,185	19
20	V								20
21	V	19 Professional Services	24,000	kel-Tech Management Co.	25.00%			(24,000)	21
22	V	34 Building Lease	38,400	Pilot House Land Trust	100.00%			(38,400)	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		\$ 62,400			\$ 17,288	\$ *	(45,112)	39

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

Facility Name & ID Number

Pilot House

0037036

Report Period Beginning:

1/1/09

Ending:

12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JoAnn Keller	Owner/Admin.	Administrator	50.00	102,138	4	10.00	Admin	\$ 24,018	17-1	1
2	James K. Keller	Owner		50.00							2
3	James A. Keller	Vice President	Director	0.00	17,453			Director	2,000	18-1	3
4											4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	973	10-1	8
9	Jacob Alley							Maintenance	4,185	6-1	9
10	James A. Keller							Administration	4,698	17-1	10
11											11
12											12
13								TOTAL	\$ 35,874		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 Pilot House

0037036

Report Period Beginning:

1/1/09

Ending: 12/31/09

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

Name of Related Organization

kel-Tech Management Co.

Street Address

158 E, Vienna Street

City / State / Zip Code

Anna, IL 62906

Phone Number

(618) 833-5070

Fax Number

(618) 833-4993

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contribution	361,283	8	\$ 1,308	\$ 24,000	\$ 87	1
2	5	UTILITIES ELEC/GAS-G	Mgmt Fee Contribution	361,283	8	2,968	24,000	197	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	361,283	8	384	24,000	25	3
4	6	GROUPS MAINT-B	Mgmt Fee Contribution	361,283	8	714	24,000	47	4
5	6	MAINT SUPPLIES-B	Mgmt Fee Contribution	361,283	8	209	24,000	14	5
6	6	MAINT VEHICLE	Mgmt Fee Contribution	361,283	8	354	24,000	24	6
7	6	PREVENTATIVE MAINT	Mgmt Fee Contribution	361,283	8	442	24,000	29	7
8	14	REPAIRS VEHICLES	Mgmt Fee Contribution	361,283	8	2,342	24,000	156	8
9	14	TRANSPORTATION	Mgmt Fee Contribution	361,283	8	5,405	24,000	359	9
10	18	DIRECTORS FEES	Mgmt Fee Contribution	361,283	8	1,200	24,000	80	10
11	19	LEGAL & ACCOUNTING	Mgmt Fee Contribution	361,283	8	1,340	24,000	89	11
12	20	DUES FEES SUBSCRIPTIONS	Mgmt Fee Contribution	361,283	8	553	24,000	37	12
13	21	BANK CHARGES	Mgmt Fee Contribution	361,283	8	89	24,000	6	13
14	21	CONTRACT SERVICES	Mgmt Fee Contribution	361,283	8	654	24,000	43	14
15	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	361,283	8	218	24,000	14	15
16	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	361,283	8	462	24,000	31	16
17	21	G & A MISC-B	Mgmt Fee Contribution	361,283	8	326	24,000	22	17
18	21	G & A MISC-SUPPLIES STOCK	Mgmt Fee Contribution	361,283	8	268	24,000	18	18
19	21	G & A SUPPLIES	Mgmt Fee Contribution	361,283	8	6,309	24,000	419	19
20	21	POSTAGE	Mgmt Fee Contribution	361,283	8	2,265	24,000	150	20
21	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	361,283	8	1,765	24,000	117	21
22	21	TELEPHONE	Mgmt Fee Contribution	361,283	8	1,963	24,000	130	22
23	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	361,283	8	818	24,000	54	23
24	21	UTILITIES - INTERNET	Mgmt Fee Contribution	361,283	8	408	24,000	27	24
25	TOTALS					\$ 32,763	\$	\$ 2,175	25

Facility Name & ID Number Pilot House

0037036

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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 kel-Tech Management Co.
 Street Address 158 E, Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	INS EMP GROUP-B	Mgmt Fee Contribution	361,283	8	\$ 24,010	\$ 24,000	\$ 1,595	1
2	22	INSURANCE W/C-B	Mgmt Fee Contribution	361,283	8	5,940	24,000	395	2
3	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	361,283	8	19,953	24,000	1,325	3
4	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	361,283	8	1,787	24,000	119	4
5	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	361,283	8	2,757	24,000	183	5
6	30	DEPRECIATION-B	Mgmt Fee Contribution	361,283	8	3,326	24,000	221	6
7	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	361,283	8	2,037	24,000	135	7
8	34	LEASE BLDG-B	Mgmt Fee Contribution	361,283	8	7,200	24,000	478	8
9	35	LEASE EQUIP-B	Mgmt Fee Contribution	361,283	8	2,613	24,000	174	9
10	10	NURSING	Mgmt Fee Contribution	361,283	8	14,653	24,000	973	10
11	17	ADMINISTRATION	Mgmt Fee Contribution	361,283	8	70,720	24,000	4,698	11
12	21	CLERICAL	Mgmt Fee Contribution	361,283	8	109,259	24,000	7,258	12
13	6	MAINTENANCE	Mgmt Fee Contribution	361,283	8	63,000	24,000	4,185	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					\$ 327,255	\$ 257,632	\$ 21,739	25

Facility Name & ID Number

Pilot House

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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		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						\$				\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	0	\$	0		\$	0	9					
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	0	\$	0		\$	0	14					
15	TOTALS (line 9+line14)					\$	0	\$	0		\$	0	15					

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

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

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

Facility Name & ID Number Pilot House

0037036

Report Period Beginning:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Vinyl/Brick Frame Wood Number of Stories 1

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Healthcare</u>	<u>10,000</u>	<u>1987</u>	<u>\$ 16,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	10,000		\$ 16,000	3

Facility Name & ID Number Pilot House

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	1988	1988	\$ 269,543	\$	31.5	\$ 8,558	\$ 8,558	\$
5									
6									
7									
8									
	Improvement Type**								
9	Sprinkler Compressor	1988		639	43	15	43		494
10	Vinyl Floor	2001		918		7			918
11	Security Alarm System	2003		700		7	100	100	700
12	Roof	2003		7,000	327	15	467	140	4,225
13	4 Emergency Lights	2004		395		7	56	56	395
14	Carpet & Tile Flooring	2004		8,211		7	1,173	1,173	8,211
15	Heating Unit	2005		1,754	157	7	251	94	1,364
16	Security Alarm Panel	2006		500		7	71	71	500
17	Hot Water Heater	2006		645	43	7	92	49	150
18	Interior Painting	2008		764		7	109	109	764
19	Counter Top	2008		1,629		7	233	233	1,629
20	New Floor	2009		1,067	1,067	7	76	(991)	1,067
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 293,765	\$ 1,637		\$ 11,229	\$ 9,592	\$ 20,417	70

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

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0037036

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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	\$ 10,015	\$ 669	\$ 669	\$ 0		\$ 4,292	71
72	Current Year Purchases	2,390	2,390	171	(2,219)		2,390	72
73	Fully Depreciated Assets	25,310		2,176	2,176		25,310	73
74					0			74
75	TOTALS	\$ 37,715	\$ 3,059	\$ 3,016	\$ (43)		\$ 31,992	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	Healthcare	1995 Ford Winstar	1995	\$ 20,720	\$	\$	\$ 0		\$ 20,720	76
77	Healthcare	2001 Ford E350 Van	2001	27,655			0		27,655	77
78	Healthcare	2005 Chev. Trail Blazer	2005	22,215		4,443	4,443		22,215	78
79							0			79
80	TOTALS			\$ 70,590	\$ 0	\$ 4,443	\$ 4,443		\$ 70,590	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)	\$ 418,070	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,696	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,688	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,992	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 122,999	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: Related Party

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><u>No staff turnover</u></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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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.

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 Pilot House

0037036

Report Period Beginning: 1/1/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 106,624	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	177,045		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,390		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	452,309		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 737,368	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	24,223		15
16	Equipment, at Historical Cost	108,304		16
17	Accumulated Depreciation (book methods)	(122,998)		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)	\$ 9,529	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 746,897	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 9,343	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,379		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,704		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,091		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Garnishments Payable	165		36
37	P/R Deductions Payable	680		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 30,362	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 30,362	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 716,535	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 746,897	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 715,997	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 715,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	538	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)	\$ 538	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 716,535	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pilot House

0037036

Report Period Beginning: 1/1/09

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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	\$ 565,219	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 565,219	3
B. Ancillary Revenue			
4	Day Care	115,720	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 115,720	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	901	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)	\$ 901	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,043	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,043	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 682,883	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	111,994	31
32	Health Care	340,832	32
33	General Administration	104,869	33
B. Capital Expense			
34	Ownership	93,167	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	31,485	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 682,347	40
41	Income before Income Taxes (line 30 minus line 40)**	536	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 536	43

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

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

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

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

Facility Name & ID Number **Pilot House**

0037036

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,711	1,935	25,326	13.09	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	1,694	1,891	22,123	11.70	18
19	Laundry					19
20	Administrator	416	416	24,018	57.74	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)	991	1,116	22,366	20.04	28
29	Resident Services Coordinator	661	744	14,910	20.04	29
30	Habilitation Aides (DD Homes)	12,049	12,910	127,886	9.91	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	17,522	19,012	\$ 236,629 *	\$ 12.45	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	31	\$ 1,484	1-3	35
36	Medical Director	As Needed	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	309	10,800	10-3	38
39	Pharmacist Consultant	As Needed	220	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	280	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	26	1,025	12-3	45
46	Other(specify) <u>Dental Consultant</u>	As Needed	1,200	10a-3	46
47	<u>Psychologist</u>	32	1,600	10a-3	47
48	<u>Administrator Consultant</u>	200	6,000	17-3	48
49	TOTAL (lines 35 - 48)	602	\$ 26,209		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 Pilot House

0037036

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Healthcare Assoc. \$960
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 593 Line 10
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Pilot House #337871 1/1991
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,485
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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 195 Has any meal income been offset against related costs? N/A 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? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Related Parties Schedule VII
 Owners Compensation
 Jan.1 2009 - Dec. 31 2009

	Totals / Entity	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt
Don Pippins	\$ -	-	-	-	
Denise Pippins	\$ -	-	-	-	
Diana Alley	\$ 50,429	14,976	-	20,800	14,653
Jo Ann Keller	\$ 126,000	102,000	24,000	-	
James K. Keller	\$ 14,400	14,400	-	-	
Jacob Alley	\$ 56,424	-	-	-	56,424
Ashley Alley	\$ 11,246	-	-	-	11,246
James A. Keller	\$ 88,166	-	-	-	70,720
	\$ 346,665	\$ 131,376	\$ 24,000	\$ 20,800	\$ 153,043

Krypton Glen
 Brook

-	-
-	-
-	-
-	-
-	-
-	-
-	-
-	17,446

\$ - \$ 17,446

Pilot House, Inc			
Analysis of Sch. V, Line 20, Col. 8			
2009			
Resident Fund Bond Renewal			300
Increase Resident Fund Bond			200
Subscriptions			216
IL Healthcare Assoc Dues			886
PAC Dues			77
Corp. Ann. Report			126
Less:			
	PAC Dues		(77)
Total			<u>\$ 1,728</u>
Pilot House			
Analysis of Sch. V, Line 36, Col. 4			
2009			
State Income Tax			24,155
Federal Income Tax			<u>16,784</u>
Total			<u>\$ 40,939</u>
Pilot House			
Analysis of Depreciation			
2009			
Sch XI, Line 83			\$ 18,688
kel-Tech Mgmt Allocation			<u>221</u>
Sch. V, Line 30, Col. 8			<u>\$ 18,909</u>
Pilot House			
Analysis Allocated Hours & Wages			
Sch18, Line 29 & 30, Col 1-4			
2009			
Eric Chileman, RSD, QMRP			
Allocation of wages:			
QMRP		60%	
RSD		40%	
Total		100%	