

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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>0035196</u></p> <p>Facility Name: <u>Tibstra House</u></p> <p>Address: <u>271 E 161st Street</u> <u>South Holland</u> <u>60473</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 596-4442</u> Fax # <u>(708) 596-4486</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/24/90</u></p> <p>Type of Ownership:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border: 1px solid black; padding: 2px;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Individual</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Trust</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Partnership</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">IRS Exemption Code <u>501(c)(3)</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Corporation</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven Goudzwaard</u> Telephone Number: <u>(708) 371-0800</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501(c)(3)</u>	<input 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>7/1/10</u> to <u>6/30/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; border: 1px solid black; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Steven J. Goudzwaard</u> (Title) <u>Director of Finance</u></td> </tr> <tr> <td style="border: 1px solid black; padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (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>Steven J. Goudzwaard</u> (Title) <u>Director of Finance</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____																												

Facility Name & ID Number Tibstra House

0035196 Report Period Beginning: 7/1/10 Ending: 6/30/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		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	5,142			5,142	13
14	TOTALS	5,142			5,142	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.05%

D. How many bed-hold days during this year were paid by the Department? 595 (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)

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 1/24/90

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2011 Fiscal Year: 2011

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

Facility Name & ID Number

Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

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	32,637	1,408	1,500	35,545		35,545		35,545		1
2	Food Purchase		41,869		41,869		41,869		41,869		2
3	Housekeeping	18,403	4,090	712	23,205		23,205		23,205		3
4	Laundry		1,244		1,244		1,244		1,244		4
5	Heat and Other Utilities			7,811	7,811		7,811		7,811		5
6	Maintenance	17,079	2,391	4,090	23,560		23,560		23,560		6
7	Other (specify):* scavenger			1,499	1,499		1,499		1,499		7
8	TOTAL General Services	68,119	51,002	15,612	134,733		134,733		134,733		8
	B. Health Care and Programs										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	318,327	2,319	1,684	322,330		322,330		322,330		10
10a	Therapy	4,570	6	991	5,567		5,567		5,567		10a
11	Activities	29,110	2,418		31,528		31,528		31,528		11
12	Social Services	45			45		45		45		12
13	CNA Training										13
14	Program Transportation		7,004		7,004		7,004		7,004		14
15	Other (specify):* Program Director	31,424			31,424		31,424		31,424		15
16	TOTAL Health Care and Programs	383,476	11,747	5,975	401,198		401,198		401,198		16
	C. General Administration										
17	Administrative	27,630			27,630		27,630		27,630		17
18	Directors Fees										18
19	Professional Services			5,770	5,770		5,770		5,770		19
20	Dues, Fees, Subscriptions & Promotions			3,020	3,020		3,020		3,020		20
21	Clerical & General Office Expenses	19,930	1,929	5,048	26,907		26,907	(2,542)	24,365		21
22	Employee Benefits & Payroll Taxes			112,936	112,936		112,936	(504)	112,432		22
23	Inservice Training & Education			279	279		279		279		23
24	Travel and Seminar			445	445		445		445		24
25	Other Admin. Staff Transportation			388	388		388		388		25
26	Insurance-Prop.Liab.Malpractice			10,373	10,373		10,373		10,373		26
27	Other (specify):* miscellaneous		467		467		467		467		27
28	TOTAL General Administration	47,560	2,396	138,259	188,215		188,215	(3,046)	185,169		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	499,155	65,145	159,846	724,146		724,146	(3,046)	721,100		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.

**Tibstra House
ID #0035196
Schedule V, ISFR Reclassifications
FY2011**

Facility Name & ID Number

Tibstra House

#0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			31,251	31,251		31,251		31,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(6,881)	(6,881)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			31,251	31,251		31,251	(6,881)	24,370			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			43,976	43,976		43,976		43,976			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			43,976	43,976		43,976		43,976			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	499,155	65,145	235,073	799,373		799,373	(9,927)	789,446			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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,881)	32		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	(2,542)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,423)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (9,423)		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	

Tibstra House

ID# 0035196
 Report Period Beginning: 7/1/10
 Ending: 6/30/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Direct Care Seminars	\$ 0	24	1
2	fundraising employee benefits	(504)	22	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	(504)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,542)	0	0	0	0	0	0	0	0	0	0	(2,542)	21
22	Employee Benefits & Payroll Taxes	(504)	0	0	0	0	0	0	0	0	0	0	(504)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,046)	0	(3,046)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,046)	0	(3,046)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

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	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(6,881)	0	0	0	0	0	0	0	0	0	0	(6,881) 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	(6,881)	0	0	0	0	0	0	0	0	0	0	(6,881) 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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,927)	0	0	0	0	0	0	0	0	0	0	(9,927) 45

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethshan Association	100%	Bethshan Assoc I & Bethshan Assoc II	Palos Heights	Bethshan Foundation	Palos Heights	Charitable Corp

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

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

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

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

Facility Name & ID Number

Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Brian Dobben, President	BOD						1
2	Ira Slagter, Vice President	BOD						2
3	Donald Poortenga, Treasurer	BOD						3
4	Kim Lagestee-Mulder, Secretary	BOD						4
5	Wayne Boss	BOD						5
6	Judy Gill	BOD						6
7	James Hofman	BOD						7
8	Tom Lemmenes	BOD						8
9	Ann Payne	BOD						9
10	Gerald VanProoyen	BOD						10
11	Howard VanDyke	BOD						11
12	James VanKampen	BOD						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

Facility Name & ID Number

Tibstra House

#

0035196

Report Period Beginning:

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	# beds	130	11	\$ 143,096	\$ 138,157	16	\$ 17,612	1
2	14	Program Transportation	# beds	130	11	28,345		16	3,489	2
3	17	Administration	# beds	130	11	224,495	224,495	16	27,630	3
4	19	Professional Services	# beds	130	11	46,919		16	5,775	4
5	20	Dues/Fees/Subscriptions	# beds	130	11	23,013		16	2,832	5
6	21	Clerical & General Office	# beds	130	11	173,351	154,800	16	21,336	6
7	22	Workers Comp	budgeted salaries	4,402,245	11	95,435		487,969	10,579	7
8	22	Other Employee Benefits	# beds	130	11	13,628		16	1,677	8
9	23	In Service Training	# beds	130	11	2,124		16	261	9
10	24	Seminars & Workshop	# beds	130	11	1,012		16	125	10
11	25	Staff Travel	# beds	130	11	3,153		16	388	11
12	26	Liability Insurance	# beds	130	11	33,464		16	4,119	12
13	27	Miscellaneous	# beds	130	11	4,120		16	507	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					\$ 792,155	\$ 517,452		\$ 96,330	25

Facility Name & ID Number

Tibstra House

0035196

Report Period Beginning:

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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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$						
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 **Tibstra House**

0035196

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 report.			\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2	
3. Under or (over) accrual (line 2 minus line 1).			\$		3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006	_____	8	FOR BHF USE ONLY		
	2007	_____	9			
	2008	_____	10			
	2009	_____	11			
	2010	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2010 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tibstra House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035196

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: Payment information from the Internet or otherwise is **not considered acceptable tax bill documentation**. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,985 B. General Construction Type: Exterior brick Frame wood Number of Stories 1 w/basement

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	16 bed ICF w/garage	18,000	1989	\$ 25,000	1
2					2
3	TOTALS	18,000		\$ 25,000	3

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	1990	1990	\$ 408,781	\$ 10,220	40	\$ 10,220		\$ 219,096	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Garage		1992	9,830	491	20	491		9,104	9
10	Landscaping		1990	2,503	63	40	63		1,307	10
11	Driveway; parking		1990	33,639		15			33,639	11
12	Washroom remodeling		1996	20,165	1,008	20	1,008		14,734	12
13	Kitchen sink & counter tops		2001	2,635	175	10	175		2,635	13
14	Front door installation		2007	1,250	83	15	83		386	14
15	Water heater		2007	5,860	586	10	586		2,432	15
16	Guardian Elite Generator		2008	17,300	1,730	10	1,730		6,272	16
17	Roof		2008	12,985	649	20	649		2,329	17
18	Siding and Facia		2009	4,500	300	15	300		689	18
19	Lennox Furnace/Air Conditioner		2010	12,540	836	15	836		1,202	19
20	Landscaping Edging / Bushes		2010	1,470	104	10	104		104	20
21	Valve Replacement		2010	4,650	168	20	168		168	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$	\$		\$	\$	\$	70
			538,108	16,413	16,413		294,097	

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

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0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 16,354	\$ 2,276	\$ 2,276	\$		\$ 10,292	71
72	Current Year Purchases	3,936	410	410			410	72
73	Fully Depreciated Assets	93,864	85	85			93,864	73
74								74
75	TOTALS	\$ 114,154	\$ 2,771	\$ 2,771	\$		\$ 104,566	75

D. Vehicle Costs. (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	client transportation	vans	2006/2008	\$ 54,043	\$ 10,808	\$ 10,808	\$	5	\$ 45,180	76
77	Executive Director	Toyota Prius	2010	2,644	529	529		5	713	77
78	Maintenance	Chevy Silverado/Ford F150	2005/2009	6,861	730	730		5	4,725	78
79										79
80	TOTALS			\$ 63,548	\$ 12,067	\$ 12,067	\$		\$ 50,618	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)	\$ 740,810	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,251	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,251	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)	\$ 449,281	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.

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning: 7/1/10

Ending: 6/30/11

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

Table with 8 columns: Line, Description, Year Constructed, Number of Beds, Original Lease Date, Rental Amount, Total Years of Lease, Total Years Renewal Option*, and another column. Rows 3-7 include Original Building, Additions, and a TOTAL row.

**

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.)

Table with 5 columns: Line, Use, Model Year and Make, Monthly Lease Payment, Rental Expense for this Period, and another column. Rows 17-21 include a TOTAL row.

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

Table with 3 columns: Line, Fiscal Year Ending, Annual Rent. Rows 12-14 show years 2012, 2013, and 2014.

* 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?</p> <p><input 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					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 Tibstra House

0035196

Report Period Beginning: 7/1/10

Ending:

6/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/11

(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	\$ 816,308	\$ 26,286	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	174,779	1,546,613	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,184	28,499	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 994,271	\$ 1,601,398	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	744,175	13
14	Buildings, at Historical Cost	538,108	5,940,773	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	177,701	1,950,678	16
17	Accumulated Depreciation (book methods)	(449,281)	(4,467,665)	17
18	Deferred Charges		48,093	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)	\$ 291,528	\$ 4,216,054	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,285,799	\$ 5,817,452	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 67,541	\$ 341,673	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		709,968	29
30	Accrued Salaries Payable	23,518	232,283	30
31	Accrued Taxes Payable (excluding real estate taxes)	473	4,526	31
32	Accrued Real Estate Taxes(Sch.IX-B)		3,071	32
33	Accrued Interest Payable		12,962	33
34	Deferred Compensation	158	1,197	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)	\$ 91,690	\$ 1,305,680	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		349,200	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)	\$	\$ 349,200	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 91,690	\$ 1,654,880	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,194,109	\$ 4,162,572	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,285,799	\$ 5,817,452	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,191,768	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,191,768	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,715)	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)	\$ (7,715)	17
	B. Transfers (Itemize):		
18	water backflow valves	4,650	18
19	landscaping	1,470	19
20	sofas (2) and chairs (2)	3,936	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 10,056	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,194,109	24 *

* This must agree with page 17, line 47.

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	\$ 784,043	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 784,043	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,881	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,881	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>miscellaneous</u>	734	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 734	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 791,658	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	134,733	31
32	Health Care	401,198	32
33	General Administration	188,215	33
B. Capital Expense			
34	Ownership	31,251	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	43,976	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 799,373	40
41	Income before Income Taxes (line 30 minus line 40)**	(7,715)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (7,715)	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 **Tibstra House**

0035196

Report Period Beginning:

7/1/10

Ending:

6/30/11

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	1,205	1,250	35,333	28.27	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	138	159	4,570	28.74	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,715	1,840	29,110	15.82	9
10	Activity Assistants					10
11	Social Service Workers	1	1	45	45.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,832	2,120	32,637	15.39	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	727	807	17,079	21.16	17
18	Housekeepers	1,154	1,400	18,403	13.15	18
19	Laundry					19
20	Administrator	223	256	17,026	66.51	20
21	Assistant Administrator					21
22	Other Administrative	232	266	10,604	39.86	22
23	Office Manager					23
24	Clerical	909	1,022	19,930	19.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,268	2,441	55,035	22.55	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,509	18,512	227,959	12.31	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Program Director</u>	833	971	31,424	32.36	33
34	TOTAL (lines 1 - 33)	27,746	31,045	\$ 499,155 *	\$ 16.08	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	25	\$ 1,500	1-3	35
36	Medical Director	21	3,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1	51	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	23	940	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	6	1,684	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	76	\$ 7,475		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

**TIBSTRA HOUSE
SCHEDULE OF STAFF TRAVEL
FY 2011**

		<u>TRAVEL</u>	-	
		<u>EXPENS</u>	<u>SEMINA</u>	
		<u>E</u>	<u>RS COST</u>	
Staff intra-agency travel for meetings at central office, etc.				
<u>11-600-675 Allocation</u>				
8/31/2010	Alzheimer's Association Pain Management & Assessment in Dementia Care Chicago, IL Val Lynch, DON		6.77	
9/8/2010	OIG Training ISR Joliet, IL Dave Tiemersma, Program Director	9.81		
11/17/2010	Healthcare Management Solutions Clinical Pathways for Successful Othotic Contracture Management Therapy Teresa Walus, OT/PT MaryKay Maatman, OT/PT		9.24 9.23	
1/25/2011	The ARC of Illinois 9th Annual QSP Leadership Conference Alsip, IL Dave Tiemersma, Program Director Peggy Mollema, QSP Amy Tiemersma, LSCW		78.30 130.50 16.06	
3/8/2011	Staff Training Associates How to Manage Disruptive Behaviors in the Residential Program Chicago, IL Peggy Mollema, QSP	26.09	129.00	
6/16/2011	The Institute on Public Policy for People with Disabilities Outcomes, Quality, and Trend Analysis Arlington Heights, IL Dave Tiemersma, Program Director		30.00	
		<u>36.00</u>	<u>409.00</u>	445.00

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

7/1/10

Ending: 6/30/11

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 372 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,976
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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? no
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? yes
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: Dreyer, Ooms, & Van Drunen Ltd
- (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

Tibstra House

ID # 0035196

Schedule XX (12) Explanation of Salary Allocation

FY2011

Dave Tiemersma	(Ln 15-5)	Program Director Salary	\$	34,757
	(Ln 10-1)	QMRP Salary	\$	9,828