

Facility Name & ID Number Hammond-Henry District Hospital

8000192 Report Period Beginning: 06/01/11 Ending: 05/31/12

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 July 2011

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>25</u>	Skilled (SNF)	<u>37</u>	<u>13,182</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>25</u>	TOTALS	<u>37</u>	<u>13,182</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,077</u>	<u>9,696</u>	<u>2,276</u>	<u>13,049</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,077</u>	<u>9,696</u>	<u>2,276</u>	<u>13,049</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.99%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

0

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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1986

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 37 and days of care provided 1,197

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 5/31/12 Fiscal Year: 5/31/12

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

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	157,542		145,817	303,359		303,359	303,359			1
2	Food Purchase										2
3	Housekeeping	112,137		36,594	148,731		148,731	148,731			3
4	Laundry	13,399		52,319	65,718		65,718	65,718			4
5	Heat and Other Utilities										5
6	Maintenance	45,217		299,085	344,302		344,302	344,302			6
7	Other (specify):*										7
8	TOTAL General Services	328,295		533,815	862,110		862,110	862,110			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	788,567	71,284	31,141	890,992		890,992	890,992			10
10a	Therapy										10a
11	Activities	46,226	3,211	5,059	54,496		54,496	54,496			11
12	Social Services	140,208		1,657	141,865		141,865	141,865			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	975,001	74,495	37,857	1,087,353		1,087,353	1,087,353			16
	C. General Administration										
17	Administrative										17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	83,476		118,670	202,146		202,146	202,146			21
22	Employee Benefits & Payroll Taxes			365,728	365,728		365,728	365,728			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*	27,196		321	27,517		27,517	27,517			27
28	TOTAL General Administration	110,672		484,719	595,391		595,391	595,391			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,968	74,495	1,056,391	2,544,854		2,544,854	2,544,854			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			292,012	292,012	292,012	(72,655)	219,357				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			292,012	292,012	292,012	(72,655)	219,357				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											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,413,968	74,495	1,348,403	2,836,866	2,836,866	(72,655)	2,764,211				45

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

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Report Period Beginning: 06/01/11

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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	(72,655)	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				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 See Pg 5A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (72,655)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	\$ (72,655)		37

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

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

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

Hammond-Henry District Hospital

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

VII. RELATED PARTIES

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

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

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

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

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

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VII. RELATED PARTIES (continued)

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

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

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

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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						\$	\$			\$								
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. \$ N/A Line # N/A

* 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.)

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 2011 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.)	2011		\$		2	
3. Under or (over) accrual (line 2 minus line 1).			\$		3	
4. Real Estate Tax accrual used for 2012 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.)		Mgmt. Alloc.	\$		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.)		Allocated from Management Co.	\$		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:	2007	_____	8	FOR BHF USE ONLY		
	2008	_____	9			
	2009	_____	10			
	2010	_____	11			
	2011	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2011 \$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME _____ COUNTY _____

FACILITY IDPH LICENSE NUMBER _____

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 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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8000192 Report Period Beginning:

06/01/11 Ending:

05/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,895 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>133,009</u>	<u>1954</u>	<u>\$ 91,835</u>	<u>1</u>
2	<u>Building</u>	<u>9,000</u>	<u>2007</u>	<u>31,500</u>	<u>2</u>
3	TOTALS	142,009		\$ 123,335	3

Facility Name & ID Number **Hammond-Henry District Hospital**

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06/01/11

Ending:

05/31/12

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	37		2011	\$ 3,423,198	\$		\$ 155,584	\$ 155,584	\$ 155,584
5									
6									
7									
8									
Improvement Type**									
9	CUSTOM DRAPERIES - CHICAGO STREET DECORATING		2011	37,250		5	7,450	7,450	7,450
10	TUB - ARJOHUNTLEIGH		2011	12,923		7	1,846	1,846	1,846
11	IN FLOOR SCALE - DIRECT SUPPLY		2011	6,895		10	690	690	690
12									
13									
14									
15	Allocated Depreciation				292,012			(292,012)	
16									
17									
18									
19									
20									
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

Facility Name & ID Number **Hammond-Henry District Hospital**

8000192

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Ending:

05/31/12

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)		\$ 3,480,267	\$ 292,012		\$ 165,570	\$ (126,442)	\$ 165,570	70

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

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	\$ 78,399	\$	\$ 3,611	\$ 3,611		\$ 66,905	71
72	Current Year Purchases	209,578		50,176	50,176		17,097	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 287,977	\$	\$ 53,787	\$ 53,787		\$ 84,002	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,891,579	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 292,012	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 219,357	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (72,655)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 249,572	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

* 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.

Facility Name & ID Number Hammond-Henry District Hospital # 8000192 Report Period Beginning: 06/01/11 Ending: 05/31/12
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 checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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 prescrpts													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 Hammond-Henry District Hospital

8000192

Report Period Beginning: 06/01/11

Ending:

05/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,509,377	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,001,641		3
4	Supply Inventory (priced at)	832,061		4
5	Short-Term Investments	1,011,295		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	225,867		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Property Taxes & Other AR</u>	1,435,117		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,015,358	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,660,156		12
13	Land	1,210,071		13
14	Buildings, at Historical Cost	45,474,380		14
15	Leasehold Improvements, at Historical Cost	(12,932,604)		15
16	Equipment, at Historical Cost	11,543,496		16
17	Accumulated Depreciation (book methods)	(6,300,723)		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): <u>Deferred Cost & Other Rec.</u>	1,100,040		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 49,754,816	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 61,770,174	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,274,432	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,430,956		29
30	Accrued Salaries Payable	1,320,756		30
31	Accrued Taxes Payable (excluding real estate taxes)	304,560		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	41,295		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>3rd Party Settlement</u>	1,153,172		36
37	<u>Deferred Rev.</u>	305,420		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,830,591	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	27,242,468		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)	\$ 27,242,468	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 33,073,059	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,697,115	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 61,770,174	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 27,685,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 27,685,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(971,930)	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) Operating Misc Rev	1,103,446	15
16	Other (describe) Non-Operating Misc Rev	879,934	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,011,450	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 28,697,115	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,214,680	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,214,680	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Hospital Net Revenue</u>	27,854,846	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,854,846	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 30,069,526	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	862,110	31
32	Health Care	1,087,353	32
33	General Administration	595,391	33
B. Capital Expense			
34	Ownership	292,012	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Hospital Expenses</u>	28,204,590	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 31,041,456	40
41	Income before Income Taxes (line 30 minus line 40)**	(971,930)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (971,930)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 **Hammond-Henry District Hospital**

8000192

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	7,706	8,531	249,227	29.21	3
4	Licensed Practical Nurses	8,064	8,603	158,087	18.38	4
5	CNAs & Orderlies	25,367	28,908	336,361	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,477	4,008	47,618	11.88	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,952	2,291	43,499	18.99	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	46,566	52,341	\$ 834,792 *	\$ 15.95	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 5,537	IDPH License Fee	\$	
				Unemployment Compensation Insurance	890	Advertising: Employee Recruitment		
				FICA Taxes	62,678	Health Care Worker Background Check		
				Employee Health Insurance	91,377	(Indicate # of checks performed _____)		
				Employee Meals	0	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*	76,472			
				Life Insurance	322			
				Cafeteria Benefit	128,304			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$		
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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									N/A			
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. No
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 0
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ See Medicare CR
- (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? 0
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
 - 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Hammond-Henry Distric

04:02 PM

6/13/2013

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-72,655	equal to	-72,655	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	219,357	equal to	219,357	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	#VALUE!	#VALUE!	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies		equal to	0	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	862,110	equal to	862,110	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,087,353	equal to	1,087,353	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	595,391	equal to	595,391	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	292,012	equal to	292,012	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	0	equal to	0	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	0	equal to	0	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	787,174	equal to	788,567	-1,393	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	47,618	equal to	46,226	1,392	FAILED	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to	140,208	-140,208	FAILED	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	0	equal to	157,542	-157,542	FAILED	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	0	equal to	45,217	-45,217	FAILED	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to	112,137	-112,137	FAILED	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to	13,399	-13,399	FAILED	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	0	equal to	0	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to	83,476	-83,476	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	834,792	equal to	1,413,968	-579,176	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	145,817	-145,817	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to	0	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	0	< or = to	31,141	-31,141	O.K.	Pg20 X14..X16+	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	5,059	-5,059	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	1,657	-1,657	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.		equal to	0	#VALUE!	#VALUE!	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to	0	#VALUE!	#VALUE!	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.		equal to	0	#VALUE!	#VALUE!	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	365,579	equal to	365,728	-149	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..		equal to	0	#VALUE!	#VALUE!	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav		equal to	0	#VALUE!	#VALUE!	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	0	equal to	0	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,197	equal to	2,276	-1,079	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	0	equal to	0	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	123,335	equal to	0	123,335	FAILED	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,480,267	equal to	0	3,480,267	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	287,977	equal to	0	287,977	FAILED	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	249,572	equal to	0	249,572	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	28,697,115	equal to	28,697,115	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-971,930	equal to	-971,930	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	61,770,174	equal to	61,770,174	0	FAILED	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!

6/13/2013 04:02:06 PM

HSA Number: _____ Name: Hammond-Henry District Hospital

Cost report period From: 06/01/11 To: 05/31/12 Base Number: 437

If this is an ICF/DD 16 facility, enter a 1 in cell C6

Licensed bed days: 13,182 Occupancy: N 13,049 Pct. of occupancy: 98.99%

Illinois Public Aid Support Rate: \$ _____

Genl Services Salary/Wage: 328,295 Col 1, Line 8 ---Audit Adj: _____

Genl Admin Salary/Wage: 110,672 Col 1, Line 28 ---Audit Adj: _____

Total Salary Wage: 1,413,968 Col 1, Line 44 ---Audit Adj: _____

Employee Benefits: 365,728 Col 8, Line 22 ---Audit Adj: _____

Total General Services: 862,110 Col 8, Line 8 ---Audit Adj: _____

Total General Admin: 595,391 Col 8, Line 28 ---Audit Adj: _____

2011 rate	\$92.37
2010 rate	_____
Variance	<u>92.37</u>

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

- 1 Determine the proportion of general services wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.
- 3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B.

General Administration

- 1 Determine the proportion of General Administration wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.
- 3 Add the proportioned fringe amount to your total General Administration expenses.
- 4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Employee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation factors are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 11 divided by 2 =
Beginning Day + Ending Day = 32 divided by 60.8 =
Beginning Year + Ending Year = 223 multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost
(from Step I-B) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupancy

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

- A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.
- B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

- C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is

35th Percentile is

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

\$328,295
\$1,413,968
 23.2180%
\$365,728

 \$84,915
\$862,110
\$947,025

\$110,672
\$1,413,968
 7.8271%

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF)
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$365,728
\$28,626
\$595,391
\$365,728
\$258,289

5.5
0.526315789
1338

1344.026316
907.00

437

1
1

\$947,025
1

\$947,025

\$258,289
1
\$258,289
\$1,205,314

\$92.37

\$1,205,314
13,049
\$92.37

13,182
0.93
12,259
13,049
-790
-263
13,049
12,786

\$1,205,314
12786

\$94.27

#N/A

\$92.37

#N/A

0.5

#N/A

\$92.37

#N/A

#N/A

\$92.37

#N/A

0.5

#N/A

#N/A

#N/A

\$92.37

#N/A

#N/A

#N/A

#N/A

7DD 16 Facilities)

centiles by HSA

<u>75th</u> <u>Percentile</u>	<u>35th</u> <u>Percentile</u>	<u>Below 35th</u> <u>Profit Ceiling</u>
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!!
6/13/2013 04:02:06 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: _____ ID: pg1!j12
=PG1!E14

HSA No.: _____ Own or Rent? (O or R) O Own or Rent Beginning: O

IF RENTED, have facilities been continuously rented from an unrelated party since prior to January 1, 1978 (Y or N):
or since the first day of operation for buildings constructed since January 1, 1978?
N

Cost Report Pd:	Licensed Beds:	37	Total Patient Days	13,049
Begin	=PG1!AB16 Licensed Bed Days:	13,182	% Occupied	98.99%
End	=PG1!AD16		Capital Days	13,049

1989 Property Tax COST: _____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: _____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: _____ (From form 787)

2011 rate	#N/A
2010 rate	_____
Variance	<u>#N/A</u>

CAPITAL CALCULATIONS

=PG1!E14

Estimate of revised capital rate due to improvements 2000-200?

- A. Determine the base year for your building from Work Table A
- B. Determine the Building Specific historical cost per bed:
 1. Work Table A, Line 24, Column (B)
 2. Total licensed beds from cost report Page 2, Line 7, column 3
 3. Line 1 divided by Line 2
 4. Regional construction inflator from Table 2
 5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even \$)
- C. Obtain the Uniform Building Value from Table 1
- D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5
 1. Building specific historical cost from Line B5
 2. Uniform building value from Line C
 3. Add Lines 1 and 2
 4. Divide by 2 to obtain average
 5. Enter 120% of line C
 6. The blended value is the lesser of Line 4 or Line 5
- E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment
- F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)
- G. Add \$2.50 to Line F for equipment, rent, vehicle and working capital.
- H. Add Lines F & G to obtain the preliminary capital rate
- I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)
 1. Enter the FY 91 capital rate
 2. Subtract the FY 91 property tax rate
 3. FY 91 rate without tax
 4. Multiply Line I3 by 115%
 5. Implementation capital rate
- J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:
 1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)
 2. Divided by: Capital Days (see below)

- 3. Equals: Per Diem Cost
- 4. Times: Property Tax Inflator (Table 3)
- 5. Equals: Updated Property Tax Cost

Capital Days

The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

- 1. Total Patient Days
- 2. Total Licensed Bed Days * .93
- 3. Capital Days (higher of Line 1 or Line 2)

K. Total Capital Rate for FY 94

- 1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I
- 2. Add Property Tax from Line J5
- 3. Total capital rate (add Lines 1 & 2)

<p>Adjust above for rate cut & COLAs (L74) x .941 x 1.03 x 1.03</p> <p>Capital rate as of ?</p> <p>Potential Rate Increase</p> <p>Estimate of annual Medicaid days</p> <p>Estimated increase in annual Medicaid revenue</p> <p>=PG1!E14</p> <p>Estimate of revised capital rate due to improvements 2000-200?</p>

\$0.00	51	51	0	0	0	12A	147	0	0	0	12D
#N/A	52	52	0	0	0	12A	148	0	0	0	12D
#N/A	53	53	0	0	0	12A	149	0	0	0	12D
	54	54	0	0	0	12A	150	0	0	0	12D
	55	55	0	0	0	12A	151	0	0	0	12D
	56	56	0	0	0	12A	152	0	0	0	12D
	57	57	0	0	0	12A	153	0	0	0	12D
	58	58	0	0	0	12A	154	0	0	0	12D
	59	59	0	0	0	12A	155	0	0	0	12D
13,049	60	60	0	0	0	12A	156	0	0	0	12D
12259	61	61	0	0	0	12A	157	0	0	0	12D
13,049	62	62	0	0	0	12A	158	0	0	0	12D
	63	63	0	0	0	12A	159	0	0	0	12D
	64	64	0	0	0	12A	160	0	0	0	12D
	65	65	0	0	0	12A	161	0	0	0	12D
#N/A	66	66	0	0	0	12A	162	0	0	0	12D
	67	67	0	0	0	12B					
#N/A	68	68	0	0	0	12B					
#N/A	69	69	0	0	0	12B					
#N/A	70	70	0	0	0	12B					
	71	71	0	0	0	12B					
	72	72	0	0	0	12B					
#N/A	73	73	0	0	0	12B					
	74	74	0	0	0	12B					
	75	75	0	0	0	12B					
#N/A	76	76	0	0	0	12B					
	77	77	0	0	0	12B					
	78	78	0	0	0	12B					
	79	79	0	0	0	12B					
	80	80	0	0	0	12B					
	81	81	0	0	0	12B					
	82	82	0	0	0	12B					
	83	83	0	0	0	12B					
	84	84	0	0	0	12B					
	85	85	0	0	0	12B					
	86	86	0	0	0	12B					
	87	87	0	0	0	12B					
	88	88	0	0	0	12B					
	89	89	0	0	0	12B					
	90	90	0	0	0	12B					
	91	91	0	0	0	12B					
	92	92	0	0	0	12B					
	93	93	0	0	0	12B					
	94	94	0	0	0	12B					
	95	95	0	0	0	12B					
	96	96	0	0	0	12B					

Calculation of Base Year, AKA Weighted Average Year		
Base year:		
Total of Column C/Total of Column B = Base Year		
386309599.3	3480266.66	111
Base Year =		2011
=PG11E14		
Estimate of revised capital rate due to improvements 2000-200?		

TABLE 2

#N/A

TABLE 3

TABLE 4

Construction Inflaters by year and HSA
 (Note: Use the 1960 Inflaters for all years prior to 1960)
 (For the FY94 Nursing Facility Rate Calculation Packet)

Property Tax Inflatior

Table 2 column

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<u>1, 2, 3, 4, 5, 10 & 11</u>	<u>Year</u>	<u>1, 2 & 10</u>	<u>3, 4 & 5</u>	<u>11</u>	<u>6, 7, 8 & 9</u>
3766	1960	6.26	6.08	6.29	6.54
4896	1961	5.67	5.52	5.66	5.87
6026	1962	5.67	5.52	5.66	5.87
7155	1963	5.67	5.52	5.66	5.87
8285	1964	5.67	5.52	5.66	5.87
9415	1965	5.67	5.52	5.66	5.87
10545	1966	5.36	5.23	5.35	5.55
11675	1967	5.1	4.97	5.08	5.28
12804	1968	4.85	4.71	4.83	5.03
13934	1969	4.61	4.48	4.59	4.79
15064	1970	4.38	4.25	4.36	4.56
16194	1971	4.01	3.89	3.98	4.15
17324	1972	3.64	3.53	3.63	3.78
18453	1973	3.36	3.26	3.36	3.48
19583	1974	3.08	3	3.09	3.19
20713	1975	2.83	2.77	2.8	2.91
21843	1976	2.73	2.65	2.74	2.82
22973	1977	2.57	2.48	2.55	2.68
24102	1978	2.37	2.29	2.38	2.49
25232	1979	2.18	2.12	2.21	2.32
26362	1980	1.96	1.92	2.02	2.08
27492	1981	1.8	1.76	1.86	1.91
28622	1982	1.67	1.63	1.72	1.76
29751	1983	1.54	1.5	1.57	1.65
30881	1984	1.51	1.47	1.55	1.62
32011	1985	1.48	1.45	1.5	1.59
33141	1986	1.46	1.42	1.46	1.55
34271	1987	1.44	1.4	1.43	1.52
35400	1988	1.4	1.36	1.39	1.46
36530	1989	1.35	1.33	1.35	1.41
37660	1990	1.32	1.31	1.33	1.34
	1991	1.29	1.29	1.3	1.31
	1992	1.26	1.26	1.27	1.26
	1993	1.25	1.24	1.25	1.23
	1994	1.22	1.22	1.22	1.19
	1995	1.2	1.2	1.19	1.17
	1996	1.12	1.11	1.13	1.12
	1997	1.1	1.09	1.1	1.1
	1998	1.08	1.07	1.07	1.07
	1999	1.04	1.04	1.04	1.04
	2000	1.02	1.02	1.02	1.03
	2001	1.00	1.00	1.00	1.00
	2002	1.00	1.00	1.00	1.00

<u>HSA</u>	<u>Rate</u>
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

<u>HSA</u>	<u>Column</u>
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

prior to 1970