

Facility Name & ID Number Stephenson Nursing Center

0004259 Report Period Beginning: _____ Ending: _____

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	160	Skilled (SNF)	160	58,560	1
2		Skilled Pediatric (SNF/PED)			2
3	2	Intermediate (ICF)	2	732	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,292	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	30,886	8,019	4,866	43,771	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,886	8,019	4,866	43,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.82%

D. How many bed-hold days during this year were paid by the Department? 342 (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 01/01/1961

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 160 and days of care provided 2,683

Medicare Intermediary WPS Medicare

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/12 Fiscal Year: 11/30/12

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

Facility Name & ID Number

Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		4,269	9,589	13,858	(11,880)	1,978	(3,873)	(1,895)		1
2	Food Purchase		805,772		805,772		805,772		805,772		2
3	Housekeeping	149,930		2,643	152,573		152,573		152,573		3
4	Laundry	115,025	49,252		164,277		164,277		164,277		4
5	Heat and Other Utilities			131,745	131,745		131,745		131,745		5
6	Maintenance	99,339	73,636	4,803	177,778		177,778		177,778		6
7	Other (specify):* central supply	22,365			22,365		22,365		22,365		7
8	TOTAL General Services	386,659	932,929	148,780	1,468,368	(11,880)	1,456,488	(3,873)	1,452,615		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	2,347,830	203,444	317,334	2,868,608		2,868,608		2,868,608		10
10a	Therapy										10a
11	Activities	125,245	1,539		126,784		126,784		126,784		11
12	Social Services	71,752	4,947		76,699		76,699		76,699		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,544,827	209,930	325,734	3,080,491		3,080,491		3,080,491		16
	C. General Administration										
17	Administrative	139,127			139,127		139,127	46,321	185,448		17
18	Directors Fees										18
19	Professional Services			12,252	12,252		12,252		12,252		19
20	Dues, Fees, Subscriptions & Promotions			13,970	13,970		13,970	(7,774)	6,196		20
21	Clerical & General Office Expenses	99,515	52,767	13,183	165,465		165,465		165,465		21
22	Employee Benefits & Payroll Taxes			994,499	994,499	11,880	1,006,379		1,006,379		22
23	Inservice Training & Education			226	226		226		226		23
24	Travel and Seminar			3,389	3,389		3,389		3,389		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	238,642	52,767	1,037,519	1,328,928	11,880	1,340,808	38,547	1,379,355		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,170,128	1,195,626	1,512,033	5,877,787		5,877,787	34,674	5,912,461		29

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

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

Facility Name & ID Number Stephenson Nursing Center

#0004259

Report Period Beginning:

Ending:

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			89,044	89,044	89,044	(133)	88,911				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			89,044	89,044	89,044	(133)	88,911				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,539		101,539	101,539		101,539				39
40	Barber and Beauty Shops		699		699	699		699				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee						312,521	312,521				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		102,238		102,238	102,238	312,521	414,759				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,170,128	1,297,864	1,601,077	6,069,069	6,069,069	347,062	6,416,131				45

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

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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	(3,873)	1		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	(133)	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	(7,774)	20		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	312,521			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 300,741		\$	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)	46,321		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 46,321		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 347,062		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Stephenson Nursing Center

ID# 0004259

Report Period Beginning:

Ending:

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Add in bed tax	\$ 312,521	42	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	312,521		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(3,873)	0	0	0	0	0	0	0	0	0	0	(3,873)	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	(3,873)	0	0	0	0	0	0	0	0	0	0	(3,873)	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	46,321	0	0	0	0	0	0	0	0	0	46,321	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	(7,774)	0	0	0	0	0	0	0	0	0	0	(7,774)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	(7,774)	46,321	0	38,547	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,647)	46,321	0	34,674	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stephenson Nursing Center# 0004259

Report Period Beginning:

Ending:

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	(133)	0	0	0	0	0	0	0	0	0	0	(133)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	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	(133)	0	0	0	0	0	0	0	0	0	0	(133)	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	312,521	0	0	0	0	0	0	0	0	0	0	312,521	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	312,521	0	0	0	0	0	0	0	0	0	0	312,521	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	300,741	46,321	0	347,062	45								

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V							2
3	V	17 County administrator				27,491	27,491	3
4	V	17 County treasurer				5,092	5,092	4
5	V	17 County Clerk				5,327	5,327	5
6	V	17 County board				7,272	7,272	6
7	V	17 County courthouse				1,139	1,139	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 46,321	\$ * 46,321	14

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

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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								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

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: _____ Ending: _____

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 Stephenson Nursing Center

0004259 Report Period Beginning:

Ending:

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

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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. \$ _____ 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.)

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.)	\$			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.)	\$			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:		2007	_____	8	
		2008	_____	9	
		2009	_____	10	
		2010	_____	11	
		2011	_____	12	
FOR BHF USE ONLY					
		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 Stephenson Nursing Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0004259

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.**

Facility Name & ID Number Stephenson Nursing Center

0004259 Report Period Beginning:

Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,954 B. General Construction Type: Exterior Block and cement Frame _____ Number of Stories 1

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing facility</u>	<u>392,040</u>	<u>1853</u>	\$	1
2					2
3	TOTALS	392,040		\$	3

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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	98			1971	\$ 613,691	\$	40	\$	\$	\$ 613,691	4
5	66			1988	1,687,286	42,182	40	42,182	0	1,033,462	5
6	Alzheimers Unit			1993	189,427	4,736	40	4,736	(0)	91,163	6
7	Garage Building			1972	2,912		20			2,912	7
8	Building			1984	149,592	3,740	40	3,740	(0)	101,854	8
	Improvement Type**										
9	Improvement			1980	15,878		10			15,878	9
10	boiler reparis			1981	1,000		15			1,000	10
11	roof repairs			1981	10,634		20			10,634	11
12	sidewalks			1982	1,276		20			1,276	12
13	Improvement			1983	2,555		25			2,555	13
14	Improvement			1987	3,816		15			3,816	14
15	Improvement			1989	27,483	687	40	687		16,146	15
16	Improvement			1992	8,038		10			8,038	16
17	Improvement			1981	1,110		10			1,110	17
18	Improvement			1994	8,557	214	40	214		3,869	18
19	Improvement			1994	8,991		40			8,991	19
20	Improvement			1995	8,258	206	40	206		3,622	20
21	parking lot expansion			1995	10,659	533	20	533		8,815	21
22	water heater			1996	2,475		20			2,475	22
23	water heater			1996	3,449		10			3,449	23
24	fire dampers			1996	744	30	25	30		487	24
25	parking lot expansion			1996	26,914	1,346	20	1,346		20,915	25
26	roof top air/heat units			1997	14,936		25			14,936	26
27	smoke detectors			1997	2,248		10			2,248	27
28	carpeting & vinyl			1997	3,828		10			3,828	28
29	roof top air/heat units			1998	14,997		10			14,997	29
30	water heater/sprinkling system			1998	17,742		10			17,742	30
31	carpeting & vinyl			1998	3,449		10			3,449	31
32	blacktopping			1971	6,755		10			6,755	32
33	roof			1979	11,804		10			11,804	33
34	roof			1978	9,092		10			9,092	34
35	roof			1978	4,546		10			4,546	35
36											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 Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Tuckpointing	1975	\$ 2,700	\$	35	\$	\$	\$ 2,700	37
38	fire doors	1975	4,443		35			4,443	38
39	plaster	1976	917		35			917	39
40	alarm system	1976	350		35			350	40
41	fire alarm	1983	1,360		10			1,360	41
42	alarm system	1990	11,316		10			11,316	42
43	water softner	1990	9,178		10			9,178	43
44	dehumidifier	1990	9,500		10			9,500	44
45	ansul fire door	1999	1,374		10			1,374	45
46	roof a/c unit	1999	11,080		10			11,080	46
47	paving	2000	7,942	318	25	318		3,972	47
48	smoke wall	2000	13,973	699	20	699		8,735	48
49	boiler	2001	4,752		10			4,752	49
50	steel door	2001	568	14	40	14		163	50
51	block heater	2002	655	34	10	34		655	51
52	temperature control	2002	1,000	100	10	100		960	52
53	manhole for sewer	2002	4,800	480	10	480		5,040	53
54	fence	2003	4,220	422	10	422		4,009	54
55	boiler and installation	2004	4,961	496	10	496		4,216	55
56	doors and frames	2008	10,520	1,052	10	1,052		4,208	56
57	Vinyl kitchen wall	2009	2,056	51	40	51		204	57
58	Kitchen doors and hardware	2009	3,617	90	40	90		360	58
59	Kitchen floor	2009	14,517	363	40	363		1,452	59
60	Ceiling grid	2009	3,431	86	40	86		344	60
61	Roof project	2009	1,053	26	40	26		104	61
62	Lighting System	2011	28,884	722	40	722		1,444	62
63	Heater element and blower	2012	9,097	227	40	227		227	63
64	Install canopy	2012	6,300	158	40	158		158	64
65	Replace flooring in front lobby	2012	12,048	301	40	301		301	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,060,754	\$ 59,314		\$ 59,313	\$ (0)	\$ 2,139,077	70

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

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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	\$ 317,730	\$ 29,598	\$ 29,598	\$		\$ 171,490	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	706,595					706,595	73
74								74
75	TOTALS	\$ 1,024,325	\$ 29,598	\$ 29,598	\$		\$ 878,085	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	Resident Use only	Ford bronco	1990	\$ 3,313	\$	\$	\$		\$ 3,313	76
77	Resident Use only	Colt Wagon	1989	9,359					9,359	77
78	Resident Use only	Dodge Van	1999	35,748					35,748	78
79										79
80	TOTALS			\$ 48,420	\$	\$	\$		\$ 48,420	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)	\$ 4,133,499	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,912	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,911	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,065,582	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 Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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 Stephenson Nursing Center # 0004259 Report Period Beginning: _____ Ending: _____

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>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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 **Stephenson Nursing Center**

0004259

Report Period Beginning:

Ending:

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of _____ (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	\$ 161,116	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	803,628		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,313,483		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Property tax receivable</u>	500,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,778,227	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,060,755		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,072,744		16
17	Accumulated Depreciation (book methods)	(3,094,196)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	826,063		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,865,366	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,643,593	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 161,871	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	245,978		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	500,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 907,849	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 907,849	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,735,744	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,643,593	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,936,035	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,936,035	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,799,709	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)	\$ 1,799,709	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,735,744	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

Ending:

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	\$ 7,338,280	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,338,280	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	1,344	13	
14	Non-Patient Meals	7,571	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)	\$ 8,915	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	3,178	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,178	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	real estate taxes	498,941	28	
28a	bequests, miscellaneous	19,464	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 518,405	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,868,778	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,468,368	31	
32	Health Care	3,080,491	32	
33	General Administration	1,328,928	33	
B. Capital Expense				
34	Ownership	89,044	34	
C. Ancillary Expense				
35	Special Cost Centers	102,238	35	
36	Provider Participation Fee		36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,069,069	40	
41	Income before Income Taxes (line 30 minus line 40)**	1,799,709	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,799,709	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? _____ 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 **Stephenson Nursing Center**

0004259

Report Period Beginning:

Ending:

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	1,642	2,080	\$ 67,183	\$ 32.30	1
2	Assistant Director of Nursing	1,928	2,080	54,959	26.42	2
3	Registered Nurses	18,730	20,392	573,077	28.10	3
4	Licensed Practical Nurses	17,200	18,653	344,626	18.48	4
5	CNAs & Orderlies	101,079	106,076	1,257,489	11.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	2,080	32,340	15.55	9
10	Activity Assistants	9,201	9,739	92,905	9.54	10
11	Social Service Workers	4,768	5,052	71,752	14.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,706	6,915	99,339	14.37	17
18	Housekeepers	14,701	15,616	149,930	9.60	18
19	Laundry	12,796	13,632	115,025	8.44	19
20	Administrator	2,008	2,080	74,728	35.93	20
21	Assistant Administrator					21
22	Other Administrative	3,792	4,160	88,762	21.34	22
23	Office Manager	1,968	2,080	36,285	17.44	23
24	Clerical	3,516	3,762	63,230	16.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,666	1,872	26,133	13.96	31
32	Other Health Care(specify)	6,137	6,594		0.00	32
33	Other(specify) <u>central supply</u>			22,365		33
34	TOTAL (lines 1 - 33)	209,758	222,863	\$ 3,170,128 *	\$ 14.22	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	8,400		36
37	Medical Records Consultant	1,950		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,853		39
40	Physical Therapy Consultant	330,951		40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	3,827		45
46	Other(specify)	15,908		46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 367,889		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

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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												
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18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Stephenson Nursing Center

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. \$595 County Nsg Home Assoc of Illinois
- (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? n/a
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,511 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. n/a
- (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. \$ 312,521
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 11,880 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ no
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ no
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Wipfli LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.