

		FOR BHF USE					

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**2013**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2013)**

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

<p><b>I. IDPH License ID Number:</b> <u>0049718</u></p> <p><b>Facility Name:</b> <u>Galena Stauss Nursing Home</u></p> <p><b>Address:</b> <u>215 Summit Street</u> <u>Galena</u> <u>61036</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Jo Daviess</u></p> <p><b>Telephone Number:</b> <u>(815) 776-1340</u> <b>Fax #</b> <u>(815) 776-7274</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>01-01-1970</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code <u>20-4560540</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Tracy Bauer</u> <b>Telephone Number:</b> <u>(815) 776-1340</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>20-4560540</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/2012</u> to <u>09/30/2013</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Tracy Bauer</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) <u>See Opinion Letter</u>            (Print Name and Title) <u>Holly S. Pokrandt, CPA Partner</u>            (Firm Name &amp; Address) <u>Wipfli LLP 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u>            (Telephone) <u>(715) 858-6627</u> <b>Fax #</b> <u>(715) 832-2345</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b> </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Tracy Bauer</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) <u>See Opinion Letter</u> (Print Name and Title) <u>Holly S. Pokrandt, CPA Partner</u> (Firm Name & Address) <u>Wipfli LLP 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u> (Telephone) <u>(715) 858-6627</u> <b>Fax #</b> <u>(715) 832-2345</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>20-4560540</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Tracy Bauer</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) <u>See Opinion Letter</u> (Print Name and Title) <u>Holly S. Pokrandt, CPA Partner</u> (Firm Name & Address) <u>Wipfli LLP 3703 Oakwood Hills Pkwy, Eau Claire, WI 54701</u> (Telephone) <u>(715) 858-6627</u> <b>Fax #</b> <u>(715) 832-2345</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718 Report Period Beginning: 10/01/2012 Ending: 09/30/2013

**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	57	Skilled (SNF)	57	20,805	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	57	TOTALS	57	20,805	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		7,262	112	7,374	8
9	SNF/PED					9
10	ICF	11,235			11,235	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,235	7,262	112	18,609	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 89.44%

**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)

None

**F. Does the facility maintain a daily midnight census?**

Yes

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**

YES  NO

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

YES  NO

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

Date started 01/01/1970

**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 5 and days of care provided 112

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: N/A Fiscal Year: 9/30/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2012 Ending: 09/30/2013

**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
	<b>A. General Services</b>										
1	Dietary	132,799		28,847	161,646		161,646		161,646		1
2	Food Purchase		192,578		192,578		192,578		192,578		2
3	Housekeeping	41,144		86	41,230		41,230		41,230		3
4	Laundry			41,204	41,204		41,204		41,204		4
5	Heat and Other Utilities			31,238	31,238		31,238		31,238		5
6	Maintenance	23,614		38,435	62,049		62,049		62,049		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	197,557	192,578	139,810	529,945		529,945		529,945		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,111,279		95,994	1,207,273		1,207,273		1,207,273		10
10a	Therapy										10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Incontinent Supplies</b>			42,852	42,852		42,852		42,852		15
16	<b>TOTAL Health Care and Programs</b>	1,111,279		138,846	1,250,125		1,250,125		1,250,125		16
	<b>C. General Administration</b>										
17	Administrative	21,008		72,563	93,571		93,571		93,571		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	3,659		12,639	16,298		16,298		16,298		21
22	Employee Benefits & Payroll Taxes			295,018	295,018		295,018		295,018		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,849	29,849		29,849		29,849		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	24,667		410,069	434,736		434,736		434,736		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,333,503	192,578	688,725	2,214,806		2,214,806		2,214,806		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Galena Stauss Nursing Home

#0049718

Report Period Beginning:

10/01/2012

Ending:

09/30/2013

## 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	
	<b>D. Ownership</b>											
30	Depreciation			63,617	63,617	35,676	99,293		99,293			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					46,600	46,600		46,600			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			82,276	82,276	(82,276)						36
37	<b>TOTAL Ownership</b>			145,893	145,893		145,893		145,893			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	8,273			8,273		8,273		8,273			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,464	55,464		55,464		55,464			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	8,273		55,464	63,737		63,737		63,737			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,341,776	192,578	890,082	2,424,436		2,424,436		2,424,436			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Galena Stauss Nursing Home

ID# 0049718

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2012

Ending:

09/30/2013

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>8</b>											
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>16</b>											
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	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	<b>TOTAL General Administration</b>	<b>0</b>	<b>28</b>											
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>0</b>	<b>29</b>											

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Galena Stauss Nursing Home# 0049718

Report Period Beginning:

10/01/2012 Ending:

09/30/2013

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	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	<b>TOTAL Ownership</b>	0	0	0	0	0	0	0	0	0	0	0	0	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2012 Ending: 09/30/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2012

Ending: 9/30/2013

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2012

Ending:

09/30/2013

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1			X	Construction of New Hospital		10/1/06	\$ 45,485,000	\$ 45,135,208	10/1/2046	6.7500	\$ 46,600	1						
2				Administration is located in								2						
3				new facility - this portion								3						
4				relates to the NH's portion								4						
5				of the administrative offices.								5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 45,485,000	\$ 45,135,208			\$ 46,600	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 45,485,000	\$ 45,135,208			\$ 46,600	15						

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 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 2013 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		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:	2008	_____	8		
	2009	_____	9		
	2010	_____	10		
	2011	_____	11		
	2012	_____	12		
				<b>FOR BHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2012	\$		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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**2012 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Galena Stauss Nursing Home COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 0049718

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 2012 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 2012.

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

**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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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 Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2012 Ending:

09/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,191 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

Blank lines for listing other business entities.

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, 2, 3, \$, 1. Row 2: 2, 2. Row 3: 3 TOTALS, \$, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2012

Ending:

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57	1962	1962	\$ 140,184	\$	47	\$	\$	\$ 140,184	4
5			1971	172,403		41			172,403	5
6			1981	57,843		Various			57,843	6
7			1988	171,479	13,922	Various	13,922		118,596	7
8			2007	899,373	35,676	Various	35,676		223,738	8
<b>Improvement Type**</b>										
9	VARIOUS ADDITIONS		4/1/1968	2,827					2,827	9
10	VAR. ADD.		4/1/1969	63					63	10
11	VAR. ADD.		4/1/1971	7,134					7,134	11
12	VAR. ADD.		4/1/1972	229					229	12
13	VAR. ADD.		4/1/1973	151					151	13
14	CURB.GUTTER&SDWLK-FRONT ENT		4/1/1981	1,003					1,003	14
15	PARKING LOT EXPAN.		4/1/1981	7,150					7,150	15
16	LANDSCAPING-HARMS		4/1/1983	489					489	16
17	GRAVEL PARKING LOT		4/1/1988	3,096					3,096	17
18	SIDEWALK		4/1/1988	185					185	18
19	FENCE AROUND CHILLER		4/1/1989	226					226	19
20	SIDEWALKS & CEMENT SLAB		4/1/1989	801					801	20
21	CHAIN LINK FENCE		4/1/1989	330					330	21
22	CONCRETE PARKING LOT		4/1/1989	1,376					1,376	22
23	GAZEBO		4/1/1989	1,282					1,282	23
24	SIDEWALKS-SPROULE		4/1/1990	716					716	24
25	LANDSCAPING		3/31/2004	1,209	121		121		1,149	25
26	CONCRETE DRIVEWAY		4/1/1991	720					720	26
27	LANDSCAPING COURTYARD		4/1/1991	1,261					1,261	27
28	PAVE PARKING LOT		4/1/1994	1,902					1,902	28
29	PHYSICAL THERAPY/HELIO PAD		4/1/1995	2,284					2,284	29
30	14 CAR BUMPERS		4/1/1996	222					222	30
31	PARKING LOT		6/1/2000	25,239	1,683		1,683		22,365	31
32	CEDAR PRIVACY FENCE		4/1/2001	1,885					1,885	32
33	132 SHRUBS		3/1/2002	1,421					1,421	33
34	LANDSCAPING		3/31/2002	929					929	34
35	2 TREES		3/31/2002	132	7		7		76	35
36	WOODEN FENCE AROUND HVAC		3/31/2002	593					593	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2012 Ending: 09/30/2013

## 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	MOVING/FLATING OF BACKFILL	3/31/2002	\$ 1,704	\$		\$ -	\$ #VALUE!	\$ 1,704	37
38	HANDICAP ENTRANCE	3/31/2002	739	49		49		566	38
39	REPAIR TO SIDEWALK (CLINIC/NH)	3/31/2002	1,136	76		76		871	39
40	MOVING/FLATTENING OF BACKFILL	11/29/2002	373					373	40
41	TWO BRONZE PLAQUES	3/20/2003	324	16		16		324	41
42	SHRUBS/LANDCAPING/MULCHING	6/5/2003	1,672	84		84		1,672	42
43	RESURFACE PARKING LOT	7/8/2003	1,392	116		116		1,218	43
44	LANDSCAPING/SHRUBS/MULCH	7/23/2003	406	20		20		406	44
45	PARKING LOT	7/25/2005	2,848	178		178		2,848	45
46	LANDSCAPING & PARKING LOT	6/1/2000	39,208	2,614		2,614		34,743	46
47	9 SHRUBS	3/31/2002	98					98	47
48	2 TREES	3/31/2002	75	4		4		43	48
49	LANDSCAPING	3/31/2002	538					538	49
50	MULCH	3/31/2002	64					64	50
51	BULLET EDGING	7/31/2003	264					264	51
52	LANDSCAPING	7/31/2003	1,185	59		59		1,185	52
53	SHRUBS	7/31/2003	1,378					1,378	53
54	VARIOUS ADDITIONS	4/1/1962	9,558					9,558	54
55	VAR. ADD.	4/1/1969	471					471	55
56	STOREROOM	4/1/1970	11,787					11,787	56
57	AIR CONDITIONING	4/1/1970	5,137					5,137	57
58	AIR CONDITIONING	4/1/1974	6,324					6,324	58
59	VARIOUS ADDITIONS	4/1/1974	1,317					1,317	59
60	STOREROOM & MTC-GENERAL	4/1/1975	35,868					35,868	60
61	STOREROOM & MTC-ELECTRICAL	4/1/1975	3,825					3,825	61
62	STOREROOM & MTC-MECHANICAL	4/1/1975	8,222					8,222	62
63	STOREROOM & MTC-SPRINKLER	4/1/1975	1,481					1,481	63
64	VARIOUS ADDITIONS	4/1/1975	111					111	64
65	ELECTRICAL 1975 ADDN	4/1/1977	268					268	65
66	STORM WINDOWS & SCREENS-1962	4/1/1977	1,031					1,031	66
67	REMODEL X-RAY ROOM	4/1/1981	11,235					11,235	67
68	HEATING,VENTING,& AIR COND	4/1/1982	1,150					1,150	68
69	INSULATION	4/1/1982	5,661					5,661	69
70	TOTAL (lines 4 thru 69)		\$ 1,662,986	\$ 54,624		\$ 54,624	\$ #VALUE!	\$ 926,368	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,662,986	\$ 54,624		\$ 54,624	\$ #VALUE!	\$ 926,368	1
2	ENCLOSED PORCH PATIO	4/1/1982	2,975					2,975	2
3	RENOVATION OF C.S. AREA	4/1/1983	1,067					1,067	3
4	LIGHT FIXTURES	4/1/1984	530					530	4
5	VINYL WALL COVERING	4/1/1984	3,975					3,975	5
6	224 CORRIDOR HANDRAIL	4/1/1984	1,435					1,435	6
7	DIETARY REMODELING	4/1/1984	1,384					1,384	7
8	MEDICAL RECORDS REMODELING	4/1/1984	603					603	8
9	ELECTRICAL WORK	4/1/1985	275					275	9
10	REMOTE THERMOSTATS	4/1/1985	1,587					1,587	10
11	WALL COVERINGS	4/1/1985	3,769					3,769	11
12	GENERAL CONTRACT	4/1/1985	32,281					32,281	12
13	ELECTRICAL	4/1/1985	19,623					19,623	13
14	MECHANICAL	4/1/1985	29,729					29,729	14
15	MILLWORK	4/1/1985	11,688					11,688	15
16	FLOORING	4/1/1985	3,847					3,847	16
17	PAINTING	4/1/1985	6,443					6,443	17
18	NEW ROOM-GIESE	4/1/1986	11,426					11,426	18
19	REMODELING-NURSERY	4/1/1986	223					223	19
20	PAINTING-TIEGS	4/1/1987	1,551					1,551	20
21	12-NEW WINDOWS-GREENCO	4/1/1987	3,873					3,873	21
22	ROOF REPLACEMENT	4/1/1988	1,090					1,090	22
23	REMODELING-OLD N.H.	4/1/1988	1,308					1,308	23
24	FLOOR COVERINGS-BLDG ADD'N	5/1/1988	3,860					3,860	24
25	PAINTING-BLDG ADD'N	5/1/1988	7,644					7,644	25
26	MILLWORK-BLDG ADD'N	5/1/1988	5,952					5,927	26
27	PLUMBING-BLDG ADD'N	5/1/1988	24,990					24,885	27
28	HEATING & A/C-BLDG ADD'N	5/1/1988	24,438					24,336	28
29	ELECTRICAL-BLDG ADD'N	5/1/1988	29,353					29,230	29
30	FIRE ALARM SYSTEM	4/1/1989	9,342					9,342	30
31	AIR CONDITIONING REPLACEMENT	4/1/1989	8,507					8,507	31
32	BOILER REPLACEMENT	4/1/1989	21,149					21,149	32
33	INSULATION	4/1/1990	948					948	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,939,847	\$ 54,624		\$ 54,624	\$ #VALUE!	\$ 1,202,876	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

## 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	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,939,847	\$ 54,624		\$ 54,624	\$	\$ 1,202,876	1
2	NEW DOORS-GREENCO	4/1/1990	2,740					2,740	2
3	PAINTING-STRUB	4/1/1990	601					601	3
4	DOOR ALARM SYSTEM	4/1/1991	750					750	4
5	REMODELING-N.H.	4/1/1992	536					536	5
6	GARAGE DOOR	4/1/1992	513					513	6
7	REMODELING-N.H.	4/1/1994	2,881	144		144		2,809	7
8	DRAIN LINE UNDER FLOOR	4/1/1996	1,819					1,819	8
9	ELECTRICAL-RADIOLOGY REMODEL	4/1/1996	13,502	750		750		13,127	9
10	GENERAL-RADIOLOGY REMODELING	4/1/1996	31,216	1,561		1,561		27,314	10
11	HELIPORT LIGHTING	4/1/1996	1,511					1,511	11
12	ROOF IMPROVEMENT	4/1/1997	856					856	12
13	PHYSICAL THERAPY ROOM REMODEL	4/1/1997	4,169	208		208		3,440	13
14	HEATING AND A/C UNITS	4/1/1999	1,649					1,649	14
15	2 STANLEY MAGIC AUTOMATIC DOORS	4/1/1999	1,221					1,221	15
16	REBUILD CHILLER	4/1/1999	3,666					3,666	16
17	FIRE ALARM IMPROVEMENTS	4/1/2000	1,376					1,376	17
18	ARMSTRONG TILE FLOORING FOR DIETARY	4/1/2000	1,287	64		64		869	18
19	FIRE ALARM SYSTEM-ADMINISTRATION	4/1/2001	905	60		60		754	19
20	REMODELING-BUSINESS OFFICE	4/1/2001	63,452	4,230		4,230		52,877	20
21	HOOD & EXHAUST WORK - DIETARY	4/1/2001	907	45		45		567	21
22	RADIOLOGY REMODEL	3/31/2002	23,995	1,600		1,600		18,396	22
23	NURSING HOME NEW CEILING	3/31/2002	2,789					2,789	23
24	NURSING HOME SHOWER FLOORS	3/31/2002	471	24		24		271	24
25	NURSING HOME REMODEL	11/4/2002	3,088	154		154		3,088	25
26	NURSING HOME THERMOSTATS & ELECTRIC	1/9/2003	2,428	121		121		2,428	26
27	AUTOMATIC ENTRANCE MED-SURG	1/28/2003	7,501					7,501	27
28	ADMINISTRATION REMODEL	3/26/2003	5,491	366		366		3,843	28
29	NURSING HOME FIRE DOOR	3/31/2003	1,310	65		65		1,310	29
30	HOSPITAL GENERATOR POWER SOURCE	3/31/2003	4,990					4,990	30
31	ELECTRICAL WORK	10/31/2003	3,736	187		187		1,775	31
32	WATER HEATERS	10/31/2003	844	84		84		802	32
33	FLOORING	10/31/2003	927					927	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,132,974	\$ 64,290		\$ 64,290	\$	\$ 1,369,990	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning:

10/01/2012 Ending: 09/30/2013

**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	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 2,132,974	\$ 64,290		\$ 64,290	\$	\$ 1,369,990	1
2	DENSITOMETER ROOM	3/31/2004	4,102					4,102	2
3	CIRCULATING BOOSTER PUMP	4/30/2004	2,708	271		271		2,573	3
4	PT REMODEL	5/1/2004	8,044	536		536		5,095	4
5	AUTOMATIC DOOR	7/1/2004	778	78		78		739	5
6	CT REMODEL	5/20/2005	58,451	2,923		2,923		24,842	6
7	CARPET-EDUCATION ROOM	7/19/2005	464					464	7
8	WOOD FLOORING-DINING ROOMS	7/19/2005	781	78		78		664	8
9	MAMMOGRAM ROOM REMODEL	8/30/2005	3,430	229		229		1,944	9
10	REMODELING-GENERAL	4/1/1994	52,851	1,957		1,957		38,170	10
11	PLUMBING	4/1/1994	4,680	234		234		4,563	11
12	HEATING,VENTING,AIR COND.	4/1/1994	11,049	552		552		10,773	12
13	ELECTRICAL	4/1/1994	21,537	1,077		1,077		20,999	13
14	PAINTING	4/1/1994	650					650	14
15	SUSPENDED CEILING	4/1/1994	2,919					2,919	15
16	CABINETS	4/1/1994	7,332	367		367		7,149	16
17	FLOOR COVERINGS	4/1/1994	4,840					4,840	17
18	ELEVATOR	4/1/1994	11,876	594		594		11,579	18
19	HAND RAIL FOR PHYSICAL THERAPY	12/17/2002	303	20		20		212	19
20	EXTENSION JOINT	11/3/2004	530					530	20
21	ELEVATOR PROCESSOR BOARD	12/1/2005	981					972	21
22	ER REMODEL/SHOWER ROOM	1/1/2006	1,671	111		111		859	22
23	GARAGE DOOR	7/1/2006	436	44		44		314	23
24	FLOORING	9/22/2006	233	23		23		175	24
25	HEATING	9/30/2007	2,126	142		142		921	25
26	SPRINKLER SYSTEM	9/30/2007	22,634	905		905		5,885	26
27	SPRINKLER SYSTEM	9/30/2007	2,220	89		89		577	27
28	HVAC UNIT	9/30/2007	7,044	470		470		3,052	28
29	PLASTIC CULVERT PIPE	9/30/2007	1,470	74		74		478	29
30	Building Components/Remodeling - 2007 Nursing Home	12/5/2007	1,381	69		69		403	30
31	Deck - Outside of NH	9/30/2010	4,998	500		500		1,749	31
32	Flooring - NH Behind Nurses' Station	9/30/2010	421	42		42		147	32
33	Windows and Doors - 4 Seasons Room near NH Dining Room	9/30/2010	5,307	265		265		929	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,381,221	\$ 75,939		\$ 75,939	\$	\$ 1,529,258	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12D, Carried Forward		\$ 2,381,221	\$ 75,939		\$ 75,939	\$	\$ 1,529,258	1
2	Landscaping	12/2/2011	738	106		106		158	2
3	Replace Flat Roof at NH	10/24/2011	48,500	4,850		4,850		7,275	3
4	Replace Kitchen Ceiling in NH	11/16/2011	2,358	236		236		354	4
5	Carpet and Flooring - Resident rooms in NH	7/13/2012	6,802	1,360		1,360		2,041	5
6	Flooring - Vinyl - NH Dining Room and Nurses Station	7/13/2012	3,892	389		389		584	6
7	Resident Room Faucets in NH Patient Rooms	11/23/2012	2,098	52		52		52	7
8	Resident Room Vanity Countertops in NH Patient Rooms	12/30/2012	1,146	38		38		38	8
9	Flashed Roof Top Duct Work on NH Building	5/30/2013	477	24		24		24	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	TOTAL (lines 1 thru 33)		\$ 2,447,230	\$ 82,994		\$ 82,994	\$	\$ 1,539,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 135,685	\$ 15,026	\$ 15,026	\$		\$ 99,419	71
72	Current Year Purchases	9,888	509	509			509	72
73	Fully Depreciated Assets	131,856	781	781			131,856	73
74								74
75	TOTALS	\$ 277,429	\$ 16,316	\$ 16,316	\$		\$ 231,784	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)	\$ 2,724,659	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,310	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,310	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,771,567	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2014</u>	\$ _____
13.	<u>/2015</u>	\$ _____
14.	<u>/2016</u>	\$ _____

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 39 Col 1	183 hrs	8,273				183	8,273	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 8,273		\$		183	\$ 8,273	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2013

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,085,867	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,202,181 )	2,461,604		3
4	Supply Inventory (priced at Cost )	329,055		4
5	Short-Term Investments	1,523,061		5
6	Prepaid Insurance	79,818		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Amounts receivable from Med	158,135		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,637,540	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,429,981		12
13	Land	559,916		13
14	Buildings, at Historical Cost	42,911,621		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	11,357,570		16
17	Accumulated Depreciation (book methods)	(21,698,666)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,059		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond issuance costs	794,328		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 40,358,809	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 45,996,349	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 706,154	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,181,668		29
30	Accrued Salaries Payable	545,044		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,523,061		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Security deposits held	94,085		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,050,012	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	43,953,540		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	Capital lease obligations	1,955,433		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 45,908,973	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 49,958,985	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,962,636)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 45,996,349	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,030,687)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,030,687)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(933,390)	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) <b>Temp restricted contributions and income</b>	9,204	15
16	Other (describe) <b>Loans forgiven from Temp Restricted Net Assc</b>	(7,763)	16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (931,949)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (3,962,636)	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,855,143	1
2	Discounts and Allowances for all Levels	(1,287,530)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,567,613	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	22,960	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 22,960	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,590,573	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	529,945	31
32	Health Care	1,250,125	32
33	General Administration	434,736	33
<b>B. Capital Expense</b>			
34	Ownership	145,893	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	8,273	35
36	Provider Participation Fee	55,464	36
<b>D. Other Expenses (specify):</b>			
37	Hospital Net Loss	3,218,411	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,642,847	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(3,052,274)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (3,052,274)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,239,721	44
45	Private Pay - Net Inpatient Revenue	1,558,669	45
46	Medicare - Net Inpatient Revenue	71,008	46
47	Other-(specify) Medicare contractals related to hospital services	(301,784)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,567,614	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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

**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	2,984	3,057	\$ 57,586	\$ 18.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,347	6,503	167,108	25.70	3
4	Licensed Practical Nurses	10,391	10,646	199,709	18.76	4
5	CNAs & Orderlies	43,005	44,062	535,786	12.16	5
6	CNA Trainees					6
7	Licensed Therapist	183	183	8,273	45.21	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,451	6,610	73,426	11.11	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,398	11,398	132,799	11.65	15
16	Dishwashers					16
17	Maintenance Workers	1,465	1,465	23,614	16.12	17
18	Housekeepers	3,844	3,844	41,144	10.70	18
19	Laundry					19
20	Administrator	1,719	1,761	52,507	29.82	20
21	Assistant Administrator					21
22	Other Administrative	149	149	21,008	140.99	22
23	Office Manager					23
24	Clerical	239	239	3,659	15.31	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	10	11	105	9.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	2,041	2,091	25,052	11.98	33
34	TOTAL (lines 1 - 33)	90,226	92,019	\$ 1,341,776 *	\$ 14.58	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

SEE ACCOUNTANTS' COMPILATION REPORT

**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		
Tracy Bauer	CEO		\$ 20,242	Workers' Compensation Insurance	\$	IDPH License Fee	\$		
Hesper Nowatski			51,246	Unemployment Compensation Insurance		Advertising: Employee Recruitment			
(Amounts are allocated - see separate cost report)	NH Administrator			FICA Taxes		Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance		Patient Background Checks			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
				Allocated Benefits from Medicare Cost Report	295,018				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,488						
B. Administrative - Other									
Description			Amount						
Supplies and Allocated administrative expenses			\$ 85,202						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 85,202						
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		
		\$			\$	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	\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Galena Stauss Nursing Home

# 0049718

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,852 Line 15
- (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. \$ 55,464  
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. \$ 65,789
- (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? N/A  
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. \$ N/A
- (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

**SEE ACCOUNTANTS' COMPILATION REPORT**