

Facility Name & ID Number The Iroquois Resident Home

0014464 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	35	Skilled (SNF)	35	12,775	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	35	TOTALS	35	12,775	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		9,474	1,736	11,210	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		9,474	1,736	11,210	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.75%

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 1958

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 44 and days of care provided 1,736

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/13 Fiscal Year: 9/30/13

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	4,953		12,151	17,104	17,104	277,921	295,025		1	
2	Food Purchase						60,939	60,939		2	
3	Housekeeping						42,156	42,156		3	
4	Laundry			46,542	46,542	46,542	45,371	91,913		4	
5	Heat and Other Utilities						33,016	33,016		5	
6	Maintenance			4,573	4,573	4,573	83,630	88,203		6	
7	Other (specify):*									7	
8	TOTAL General Services	4,953		63,266	68,219	68,219	543,033	611,252		8	
	B. Health Care and Programs										
9	Medical Director									9	
10	Nursing and Medical Records	897,863	20,476	14,317	932,656	932,656	31,754	964,410		10	
10a	Therapy			3,447	3,447	3,447		3,447		10a	
11	Activities	34,362		5,182	39,544	39,544		39,544		11	
12	Social Services									12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	932,225	20,476	22,946	975,647	975,647	31,754	1,007,401		16	
	C. General Administration										
17	Administrative						96,450	96,450		17	
18	Directors Fees									18	
19	Professional Services									19	
20	Dues, Fees, Subscriptions & Promotions			3,710	3,710	3,710		3,710		20	
21	Clerical & General Office Expenses	28,467	23,810	6,807	59,084	59,084	113,974	173,058		21	
22	Employee Benefits & Payroll Taxes			68,692	68,692	68,692	135,744	204,436		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			3,611	3,611	3,611		3,611		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice						5,837	5,837		26	
27	Other (specify):*									27	
28	TOTAL General Administration	28,467	23,810	82,820	135,097	135,097	352,005	487,102		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	965,645	44,286	169,032	1,178,963	1,178,963	926,792	2,105,755		29	

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			68,383	68,383	68,383	68,383					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			1,624	1,624	1,624	1,624					35
36	Other (specify):*											36
37	TOTAL Ownership			70,007	70,007	70,007	70,007					37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		372		372	372	372					39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			24,090	24,090	24,090	24,090					42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		372	24,090	24,462	24,462	24,462					44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	965,645	44,658	263,129	1,273,432	1,273,432	926,792	2,200,224				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 The Iroquois Resident Home

0014464

Report Period Beginning: 10/1/12

Ending: 9/30/13

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	(826)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (826)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	927,618		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 927,618		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 926,792		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

The Iroquois Resident Home

ID# 0014464

Report Period Beginning: 10/1/12

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Iroquois Resident Home# 0014464

Report Period Beginning:

10/1/12

Ending:

9/30/13

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	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	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number The Iroquois Resident Home

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Ending:

Summary B

9/30/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	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	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number The Iroquois Resident Home

0014464

Report Period Beginning:

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Ending:

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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
Iroquois Memorial Hospital	100			Iroquois Home Care	Watseka, IL	Hospital
					Watseka, IL	DME retailer

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

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

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

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

Facility Name & ID Number

The Iroquois Resident Home

0014464

Report Period Beginning:

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Ending:

9/30/13

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	Dennis Wittenborn	BOD						1
2	Roger Dittrich	BOD						2
3	Cindy Sumner	BOD						3
4	Dan Tincher	BOD						4
5	Mike Tilstra	BOD						5
6	Mel Ward	BOD						6
7	Maggie Martin	BOD						7
8	Philip Zumwalt, MD	BOD						8
9	Steven Knapp	BOD						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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/12 Ending: 9/30/13

VII. RELATED PARTIES (continued)

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

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

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

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Iroquois Memorial Hospital
 Street Address 200 Fairman Ave
 City / State / Zip Code Watseka, IL 60970
 Phone Number (815) 432-5841
 Fax Number (815) 432-7870

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	22	Employee Benefits	Gross Salaries	15,774,266	\$ 1,776,051	\$ 0	965,645	\$ 108,724	1
2	21	Employee Benefits - Salary	Gross Salaries	15,774,266	166,448	166,448	965,645	10,189	2
3	21	Admitting	Gross Charges	67,263,369	572,351	329,216	2,002,335	17,038	3
4	10	Purchasing, Rec, & Stores	Costed Req's	2,814,182	184,199	116,333	44,286	2,899	4
5	21	Data Processing	Time Spent	656,499	794,463	217,155	58,144	70,363	5
6	21	Communications	# of Phones	227	162,648	0	9	6,449	6
7	21	Business Office	Gross Charges	67,263,369	333,756	289,463	2,002,335	9,935	7
8	17	Admin and General	Accum Cost	30,322,122	1,937,839	596,762	1,509,192	96,450	8
9	5	Heat	Square Feet	114,380	392,756	0	9,615	33,016	9
10	6	Maintenance	Square Feet	114,380	994,868	263,663	9,615	83,630	10
11	4	Laundry	Pounds	361,330	106,534	38,762	153,885	45,371	11
12	3	Housekeeping	Square Feet	111,401	488,421	298,990	9,615	42,156	12
13	1	Dietary	Meals	47,410	409,048	181,645	32,212	277,921	13
14	2	Food	Meals	47,410	89,691	0	32,212	60,939	14
15	22	Cafeteria	FTE's	26,140	260,429	171,031	2,795	27,846	15
16	10	Medical Records	Gross Charges	73,000,600	1,052,006	517,373	2,002,335	28,855	16
17	26	Property Insurance	Square Feet	137,708	29,905	0	9,615	2,088	17
18	26	Malpractice Insurance	Accum Cost	30,322,122	75,330	0	1,509,192	3,749	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 9,826,743	\$ 3,186,841		\$ 927,618	25

Facility Name & ID Number

The Iroquois Resident Home

0014464

Report Period Beginning:

10/1/12

Ending:

9/30/13

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		8	9	10					
		Related**					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 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. (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:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Iroquois Resident Home COUNTY Iroquois County

FACILITY IDPH LICENSE NUMBER 0014464

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 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 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 The Iroquois Resident Home

0014464 Report Period Beginning:

10/1/12 Ending:

9/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,615 B. General Construction Type: Exterior Brick 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).

Hospital (XX Beds), Home Health, Hospice, Rural Health Clinics, Clinics
Total other square feet - 128,093

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1		<u>9,615</u>	<u>1958</u>	<u>\$ 57,278</u>	1
2					2
3	TOTALS	<u>9,615</u>		<u>\$ 57,278</u>	3

Facility Name & ID Number The Iroquois Resident Home

0014464

Report Period Beginning:

10/1/12

Ending:

9/30/13

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	35		1958	1958	\$ 296,212	\$	40	\$	\$	\$ 296,212	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		ROOFING	1976		27,273		20			27,273	9
10		CENTRAL A/C	1976		108,539		15			108,539	10
11		SPRINKLER SYSTEM	1977		20,560		20			20,560	11
12		5 DOOR SENSORS	1986		5,087		10			5,087	12
13		INSULATION WORK	1987		56,995		10			56,995	13
14		SEAL & WATERPROOF	1988		6,517		10			6,517	14
15		PAINT & WALLPAPER HALLS	1989		5,363		5			5,363	15
16		FLOORING	1989		6,243		10			6,243	16
17		ARCHITECT FEES	1990		500		15			500	17
18		LAND PREP RH GARDEN	1990		3,935		20			3,935	18
19		SHELVING	1990		619		20			619	19
20		SHELVING	1990		619		20			619	20
21		PAINTING, WALLPAPER, ETC.	1990		5,250		5			5,250	21
22		REMODELING	1990		6,684		10			6,684	22
23		RH GARDEN PATIO MASONRY WORK	1991		45,275		20			45,275	23
24		RH GARDEN IRRIGATION	1991		3,900		15			3,900	24
25		LANDSCAPING	1992		3,754		20			3,754	25
26		FENCING - GARDEN	1992		2,111		20			2,111	26
27		FENCING - CHAIN LENGTH	1992		2,595		20			2,595	27
28		PAVILLION	1992		6,540		20			6,540	28
29		GUTTERS	1992		1,200		15			1,200	29
30		LIGHTING	1992		7,000		15			7,000	30
31		PAINTING & PAPERING	1992		9,245		5			9,245	31
32		PARKING LOT NE	1995		58,302	2,915	20	2,915		53,929	32
33		RH GARDEN SIDEWALK	1995		2,480		15			2,480	33
34		8 X 8 PAIR ALUM DOORS	1995		3,093		10			3,093	34
35		PINE HAND RAILS	1995		383		10			383	35
36		LOT LITE POLE FEED	1996		1,081	54	20	54		945	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 The Iroquois Resident Home

0014464

Report Period Beginning:

10/1/12

Ending:

9/30/13

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	PARKING LOT	1997	\$ 144,218	\$ 7,211	20	\$ 7,211	\$	\$ 118,980	37
38	LANDSCAPING - RH	1998	7,810		10			7,810	38
39	ARCH FEES	1998	19,585	652	15	652		19,585	39
40	BEDS	1998	57,478		12			57,478	40
41	CUBICAL CURTAINS (80)	1999	32,980		5			32,980	41
42	SIDE WALKS WEST & SOUTH	1999	2,305	154	15	154		2,230	42
43	REMODELING RH	1999	17,488		5			17,488	43
44	#2529 HOM DELTA LAU FAUCETS (14)	1999	2,085	104	20	104		1,510	44
45	REMODELING RESTROOMS	1999	69,743	3,487	20	3,487		50,563	45
46	TILE	1999	22,658		5			22,658	46
47	GIFT HAND RAIL 1.5 ROUND	1999	1,708	114	15	114		1,538	47
48	RH REMODELING	1999	27,360	1,824	15	1,824		24,624	48
49	SIDEWALKS M & K CENTER	1999	833	56	15	56		750	49
50	NURSE CALL SYSTEM	1999	13,747		10			13,747	50
51	FLOOR TILE	2000	19,932	1,329	15	1,329		17,939	51
52	RH REMODELING	2000	1,360		5			1,360	52
53	ASBESTOS PROGRAM	2000	6,212		5			6,212	53
54	LIGHTS & WIRING	2000	5,885	392	15	392		5,295	54
55	ARCH FEES	2000	580		5			580	55
56	RH REMODELING	2000	45,000	3,000	15	3,000		40,500	56
57	OAK CABINETS	2000	6,160	411	15	411		5,546	57
58	RH REMODELING & PAINT	2001	356		5			356	58
59	RH REMODELING - COUNTER TOPS (16)	2001	1,794	90	20	90		1,123	59
60	HEADS IN REST ROOMS (4)	2001	735	37	20	37		460	60
61	FAUCETS (3)	2001	517	26	20	26		324	61
62	CERAMIC TILE & FLOOR FIVE ROOMS	2001	4,650	233	20	233		2,907	62
63	REMODELING - ELECTRICAL (8 ROOMS)	2004	2,524	168	15	168		2,102	63
64	RH - REMODELING ELECTRICAL	2001	43,796	2,920	15	2,920		36,498	64
65	CABINETS, 8 DRAWER OAK	2002	2,710	181	15	181		2,079	65
66	FAN COIL UNIT	2002	11,469	765	15	765		8,794	66
67	REMODELING RH	2002	81,294	5,420	15	5,420		62,326	67
68	ARCH FEES	2003	13,259		5			13,259	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,365,586	\$ 31,540		\$ 31,540	\$	\$ 1,272,448	70

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

Facility Name & ID Number The Iroquois Resident Home

0014464

Report Period Beginning:

10/1/12

Ending:

9/30/13

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 12A, Carried Forward		\$ 1,365,586	\$ 31,540		\$ 31,540	\$	\$ 1,272,448	1
2	DOOR & FRAME	2003	6,665	444	15	444		4,665	2
3	RH-IDPH	2003	7,027		5			7,027	3
4	RH-IDPH	2003	8,376		5			8,376	4
5	LEVEL & LOCK ANDERSON LOCK	2004	4,965	497	10	497		4,717	5
6	SCONCES & HANGING PENDANT BELLACOR	2004	5,875	392	15	392		3,722	6
7	PAINTING (DEXTER DECORATING)	2004	13,848		5			13,848	7
8	PLUMBING (JENTER INC)	2004	32,604	1,630	20	1,630		15,486	8
9	ENTIRE WHITE CABINETRY & VINIONEER	2004	5,663	378	15	378		3,587	9
10	FLOORING - KINDON'S	2004	14,315	954	15	954		9,066	10
11	PENNER PT CARE - CASCAE WHIRLPOOL SYST	2004	13,695	1,370	10	1,370		13,011	11
12	REMODELING RH	2004	45,388	3,026	15	3,026		28,746	12
13	CERAMIC TIME	2004	28,590	1,430	20	1,430		13,581	13
14	CARPET SHAW	2004	17,968		5			17,968	14
15	FIXTURES	2004	13,017	1,302	10	1,302		12,367	15
16	MISC REMODELING - RH	2004	7,104	710	10	710		6,748	16
17	SMOKE DETECTOR - IDPH - SIMPLEX	2004	4,201	420	10	420		3,991	17
18	NURSES STATION	2004	23,000	2,300	10	2,300		21,850	18
19	CHART RACK CABINET	2004	2,317	116	20	116		1,101	19
20	PIPE RH CHILLED WATER LOOP	2005	8,450	338	25	338		2,873	20
21	WANTER GUARD SYSTEM	2006	13,663	1,366	10	1,366		10,247	21
22	CONCRETE SIDEWALK & HAND RAILS	2009	12,760	851	15	851		3,828	22
23	STEEL SMOKE BARRIER - RH	2012	8,694	531	15	531		580	23
24	RH CANOPY/AWNING	2013	6,710	186	15	186		186	24
25	INSTALL RH HEATING/VENTILATION & AC UPGRADE	2013	310,794	15,540	15	15,540		15,540	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,981,275	\$ 65,320		\$ 65,320	\$	\$ 1,495,558	34

**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	\$ 50,946	\$ 3,063	\$ 3,063	\$		\$ 37,815	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	78,813					78,813	73
74								74
75	TOTALS	\$ 129,759	\$ 3,063	\$ 3,063	\$		\$ 116,628	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)	\$ 2,168,312	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,383	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,383	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)	\$ 1,612,186	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/12 Ending: 9/30/13
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			4 Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Iroquois Resident Home

0014464

Report Period Beginning: 10/1/12

Ending:

9/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 394,043	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	18,764	4,274,214	3
4	Supply Inventory (priced at)		1,058,901	4
5	Short-Term Investments		475,747	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		1,749,479	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Third party reimbursement</u>		934,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 18,764	\$ 8,886,384	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,494,601	12
13	Land	57,278	249,035	13
14	Buildings, at Historical Cost	1,981,275	24,171,758	14
15	Leasehold Improvements, at Historical Cost		483,750	15
16	Equipment, at Historical Cost	129,759	15,082,415	16
17	Accumulated Depreciation (book methods)	(1,612,186)	(25,951,555)	17
18	Deferred Charges		86,484	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Trust)		7,610,355	22
23	Other(specify): <u>CIP</u>		272,284	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 556,126	\$ 23,499,127	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 574,890	\$ 32,385,511	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 2,218,224	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		2,181,336	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)	\$	\$ 4,399,560	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		2,171,020	39
40	Mortgage Payable			40
41	Bonds Payable		4,235,000	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Asset Retirement Obligation</u>		288,143	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,694,163	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 11,093,723	46
47	TOTAL EQUITY(page 18, line 24)	\$ 574,890	\$ 21,291,788	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 574,890	\$ 32,385,511	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 111,115	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 111,115	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	463,775	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)	\$ 463,775	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)	\$ 574,890	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,002,335	1
2	Discounts and Allowances for all Levels	(265,128)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,737,207	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,737,207	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	68,219	31
32	Health Care	975,647	32
33	General Administration	135,097	33
B. Capital Expense			
34	Ownership	70,007	34
C. Ancillary Expense			
35	Special Cost Centers	24,462	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)*	\$ 1,273,432	40
41	Income before Income Taxes (line 30 minus line 40)**	463,775	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 463,775	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue	1,535,059	45
46	Medicare - Net Inpatient Revenue	202,148	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,737,207	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 The Iroquois Resident Home

0014464

Report Period Beginning:

10/1/12

Ending:

9/30/13

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	2,080	2,080	\$ 68,806	\$ 33.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,431	5,431	145,559	26.80	3
4	Licensed Practical Nurses	15,386	15,386	310,789	20.20	4
5	CNAs & Orderlies	30,288	30,288	372,709	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,828	2,828	34,362	12.15	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	48	48	4,953	103.19	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,083	2,083	28,467	13.67	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	58,144	58,144	\$ 965,645 *	\$ 16.61	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	0	10,010	16,3	39
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant	57	3,447	10a,3	43
44	Activity Consultant			44	
45	Social Service Consultant			45	
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	57	\$ 13,457		49

C. CONTRACT NURSES

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

Facility Name & ID Number The Iroquois Resident Home

0014464

Report Period Beginning: 10/1/12

Ending: 9/30/13

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
<u>Thomas McCann</u>			\$	<u>Workers' Compensation Insurance</u>		\$	<u>IDPH License Fee</u>	\$ <u>332</u>
<u>(salary included in overhead-</u>				<u>Unemployment Compensation Insurance</u>			<u>Advertising: Employee Recruitment</u>	
<u>non of his salary is allocated</u>				<u>FICA Taxes</u>		<u>68,692</u>	<u>Health Care Worker Background Check</u>	
<u>directly to the resident home)</u>				<u>Employee Health Insurance</u>			<u>(Indicate # of checks performed)</u>	
				<u>Employee Meals</u>			<u>Illinois Health Care Assn</u>	<u>2,226</u>
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>			<u>Newspaper/Magazine/Online book sub</u>	<u>542</u>
				<u>Medicare cost report expense (allocated</u>			<u>Misc. Dues</u>	<u>610</u>
				<u>benefits)</u>		<u>136,570</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount			\$ <u>205,262</u>		\$ <u>3,710</u>
			\$				Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services						\$	Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
			\$					
							In-State Travel	
							Seminar Expense	<u>3,611</u>
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ <u>3,611</u>

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number The Iroquois Resident Home# 0014464

Report Period Beginning:

10/1/12

Ending:

9/30/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assn \$2,226
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes 826
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 35
- (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? 15 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,269 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ 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. \$ 24,090
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. \$ 27,846 Has any meal income been offset against related costs? Yes Indicate the amount. \$ Offset on Medicare Cost
- (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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Kerber, Eck & Braeckel, 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.