

Facility Name & ID Number Tibstra House

0035196 Report Period Beginning: 7/1/12 Ending: 6/30/13

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,657			5,657	13
14	TOTALS	5,657			5,657	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.87%

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)

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

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

YES NO

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

YES NO

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

Date started 1/24/90

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2013 Fiscal Year: 2013

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

Facility Name & ID Number

Tibstra House

0035196

Report Period Beginning:

7/1/12

Ending:

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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	33,449	2,051	2,308	37,808		37,808	37,808			1
2	Food Purchase		49,380		49,380		49,380	49,380			2
3	Housekeeping	24,836	4,954	1,271	31,061		31,061	31,061			3
4	Laundry		1,401		1,401		1,401	1,401			4
5	Heat and Other Utilities			8,642	8,642		8,642	8,642			5
6	Maintenance	17,409	5,158	5,930	28,497		28,497	28,497			6
7	Other (specify):* scavenger			1,680	1,680		1,680	1,680			7
8	TOTAL General Services	75,694	62,944	19,831	158,469		158,469	158,469			8
	B. Health Care and Programs										
9	Medical Director			3,300	3,300		3,300	3,300			9
10	Nursing and Medical Records	320,592	2,260	357	323,209		323,209	323,209			10
10a	Therapy	6,000		425	6,425		6,425	6,425			10a
11	Activities	28,486	3,406		31,892		31,892	31,892			11
12	Social Services	1,866			1,866		1,866	1,866			12
13	CNA Training		61		61		61	61			13
14	Program Transportation		8,412		8,412		8,412	8,412			14
15	Other (specify):* Program Director	32,331			32,331		32,331	32,331			15
16	TOTAL Health Care and Programs	389,275	14,139	4,082	407,496		407,496	407,496			16
	C. General Administration										
17	Administrative	38,649			38,649		38,649	38,649			17
18	Directors Fees										18
19	Professional Services			7,227	7,227		7,227	7,227			19
20	Dues, Fees, Subscriptions & Promotions			1,156	1,156		1,156	1,156			20
21	Clerical & General Office Expenses	14,611	1,895	5,567	22,073		22,073	(2,541)	19,532		21
22	Employee Benefits & Payroll Taxes			133,313	133,313		133,313	(423)	132,890		22
23	Inservice Training & Education			232	232		232		232		23
24	Travel and Seminar			444	444		444	(74)	370		24
25	Other Admin. Staff Transportation			407	407		407		407		25
26	Insurance-Prop.Liab.Malpractice			11,185	11,185		11,185		11,185		26
27	Other (specify):* miscellaneous		870		870		870		870		27
28	TOTAL General Administration	53,260	2,765	159,531	215,556		215,556	(3,038)	212,518		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	518,229	79,848	183,444	781,521		781,521	(3,038)	778,483		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			25,527	25,527	25,527	25,527	25,527				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,045	1,045	1,045	1,045	1,045				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			26,572	26,572	26,572	26,572	26,572				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,481	48,481	48,481	48,481	48,481				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			48,481	48,481	48,481	48,481	48,481				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	518,229	79,848	258,497	856,574	856,574	(3,038)	853,536				45

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

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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	(2,541)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,541)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,541)		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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non Direct Care Seminars	\$ (74)	24	1
2	fundraising employee benefits	(423)	22	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(497)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tibstra House# 0035196

Report Period Beginning:

7/1/12

Ending:

6/30/13

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,541)	0	0	0	0	0	0	0	0	0	0	(2,541)	21
22	Employee Benefits & Payroll Taxes	(423)	0	0	0	0	0	0	0	0	0	0	(423)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(74)	0	0	0	0	0	0	0	0	0	0	(74)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,038)	0	0	0	0	0	0	0	0	0	0	(3,038)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,038)	0	0	0	0	0	0	0	0	0	0	(3,038)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tibstra House# 0035196

Report Period Beginning:

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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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,038)	0	0	0	0	0	0	0	0	0	0	(3,038)	45

Facility Name & ID Number Tibstra House

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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
Bethshan Association	100%	Bethshan Association I	Palos Heights	Bethshan Foundation	Palos Heights	Charitable Corp

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item							
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

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Brian Dobben, President	BOD						1
2	Sally Poortenga, Vice President	BOD						2
3	Jori Brink, Treasurer	BOD						3
4	Ann Payne, Secretary	BOD						4
5	Wayne Boss	BOD						5
6	Judy Gill	BOD						6
7	Jack Hoekstra	BOD						7
8	Tom Lemmenes	BOD						8
9	Julie Sather	BOD						9
10	Howard VanDyke	BOD						10
11	James VanKampen	BOD						11
12	Clint Verhagen	BOD						12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	none								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	# beds	131	14	\$ 142,978	\$ 138,816	16	\$ 17,463	1
2	14	Program Transportation	# beds	131	14	35,947		16	4,390	2
3	17	Administration	# beds	131	14	316,400	316,400	16	38,644	3
4	19	Professional Services	# beds	131	14	59,175		16	7,227	4
5	20	Dues/Fees/Subscriptions	# beds	131	14	7,256		16	886	5
6	21	Clerical & General Office	# beds	131	14	135,809	119,667	16	16,587	6
7	22	Workers Comp	budgeted salaries	4,663,798	14	96,428		508,370	10,511	7
8	22	Other Employee Benefits	# beds	131	14	19,026		16	2,324	8
9	23	In Service Training	# beds	131	14	500		16	61	9
10	24	Seminars & Workshop	# beds	131	14	999		16	122	10
11	25	Staff Travel	# beds	131	14	3,242		16	396	11
12	26	Liability Insurance	# beds	131	14	37,339		16	4,560	12
13	27	Miscellaneous	# beds	131	14	5,242		16	640	13
14	32	Interest	# beds	131	14	8,556		16	1,045	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 868,897	\$ 574,883		\$ 104,856	25

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Report Period Beginning:

7/1/12

Ending:

6/30/13

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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	First Midwest Bank		X	cash flow	interest only	various	122,137		none	0.0400	1,045						
7																	
8																	
9	TOTAL Facility Related						\$ 122,137	\$			\$ 1,045						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 122,137	\$			\$ 1,045						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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 Tibstra House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035196

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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	\$ <u>_____</u>	\$ <u>_____</u>

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 Tibstra House

0035196 Report Period Beginning:

7/1/12 Ending:

6/30/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Tibstra House

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1990	1990	\$ 408,781	\$ 10,220	40	\$ 10,220	\$	\$ 239,535
5									
6									
7									
8									
Improvement Type**									
9	Garage	1992		9,830	235	20	235		9,830
10	Landscaping	1990		2,503	63	40	63		1,432
11	Driveway; parking	1990		33,639		15			33,639
12	Washroom remodeling	1996		20,165	1,008	20	1,008		16,751
13	Kitchen sink & counter tops	2001		2,635		10			2,635
14	Front door installation	2007		1,250	83	15	83		552
15	Water heater	2007		5,860	586	10	586		3,604
16	Guardian Elite Generator	2008		17,300	1,730	10	1,730		9,732
17	Roof	2008		12,985	649	20	649		3,628
18	Siding and Facia	2009		4,500	300	15	300		1,289
19	Lennox Furnace/Air Conditioner	2010		12,540	836	15	836		2,874
20	Landscaping Edging / Bushes	2010		1,470	147	10	147		398
21	Valve Replacement	2010		4,650	233	20	233		633
22	Install accessible ceramic tiled showers (2) with plumbing fixtures	2012		10,550	703	15	703		881
23	Install drywall, floor, ceramic tiled showers (8)	2013		30,905	887	15	887		887
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Tibstra House

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	579,563	\$	17,680	\$	17,680	\$	328,300	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 15,542	\$ 2,099	\$ 2,099	\$		\$ 10,455	71
72	Current Year Purchases	1,277	137	137			137	72
73	Fully Depreciated Assets	83,578	202	202			83,578	73
74								74
75	TOTALS	\$ 100,397	\$ 2,438	\$ 2,438	\$		\$ 94,170	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	client transportation	Ford van 2006/Honda Odyssey 2006/2008	2006/2008	\$ 54,043	\$ 3,516	\$ 3,516	\$	5	\$ 54,043	76
77	Executive Director	Toyota Camry 2012	2013	2,434	140	140		5	140	77
78	Maintenance	Ford superduty2011/Ford F150 2009/2011	2009/2011	6,877	1,375	1,375		5	4,097	78
79	Executive Director	Toyota Prius 2010	2010	disposed	378	378			disposed	79
80	TOTALS			\$ 63,354	\$ 5,409	\$ 5,409	\$		\$ 58,280	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)		\$ 768,314	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 25,527	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 25,527	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)		\$ 480,750	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning: 7/1/12

Ending: 6/30/13

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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	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 Tibstra House# 0035196Report Period Beginning: 7/1/12

Ending:

6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13

(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	\$ 698,706	\$ 118,265	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	317,131	1,429,322	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,394	30,995	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,019,231	\$ 1,578,582	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	884,175	13
14	Buildings, at Historical Cost	579,563	7,002,356	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	163,751	1,928,071	16
17	Accumulated Depreciation (book methods)	(480,750)	(4,592,023)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Progress</u>		27,050	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 287,564	\$ 5,249,629	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,306,795	\$ 6,828,211	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 110,009	\$ 459,833	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		685,393	29
30	Accrued Salaries Payable	35,538	302,342	30
31	Accrued Taxes Payable (excluding real estate taxes)	900	7,983	31
32	Accrued Real Estate Taxes(Sch.IX-B)		7,196	32
33	Accrued Interest Payable		13,755	33
34	Deferred Compensation	241	1,824	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)	\$ 146,688	\$ 1,478,326	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,086,700	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,086,700	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 146,688	\$ 2,565,026	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,160,107	\$ 4,263,185	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,306,795	\$ 6,828,211	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,196,844	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,196,844	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(67,642)	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)	\$ (67,642)	17
B. Transfers (Itemize):			
18	Building improvements	30,905	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 30,905	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,160,107	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	\$ 788,932		1
2	Discounts and Allowances for all Levels	()		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 788,932		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)	\$ 788,932		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	158,469		31
32	Health Care	407,496		32
33	General Administration	215,556		33
B. Capital Expense				
34	Ownership	26,572		34
C. Ancillary Expense				
35	Special Cost Centers			35
36	Provider Participation Fee	48,481		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 856,574		40
41	Income before Income Taxes (line 30 minus line 40)**	(67,642)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (67,642)		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 630,045	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SS/VA</u>	158,322	47
48	Other-(specify) <u>client fees</u>	565	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 788,932	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Tibstra House

0035196

Report Period Beginning:

7/1/12

Ending:

6/30/13

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		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	1,140	33,753	27.78	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist	165	6,000	30.93	7
8	Rehab/Therapy Aides				8
9	Activity Director	1,628	28,486	15.18	9
10	Activity Assistants				10
11	Social Service Workers	44	1,866	38.88	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,873	33,449	15.74	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	658	17,409	22.76	17
18	Housekeepers	1,563	24,836	13.57	18
19	Laundry				19
20	Administrator	215	17,984	70.80	20
21	Assistant Administrator				21
22	Other Administrative	428	20,665	40.68	22
23	Office Manager				23
24	Clerical	632	14,611	19.72	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,064	55,938	22.96	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	16,023	230,901	12.86	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>Program Director</u>	884	32,331	30.44	33
34	TOTAL (lines 1 - 33)	27,317	\$ 518,229 *	\$ 16.71	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	36	\$ 2,308	1-3	35
36	Medical Director	52	3,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1	35	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	390	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	2	357	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	97	\$ 6,390		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joseph Lanenga	Executive Director	0	\$ 17,984	Workers' Compensation Insurance	\$ 10,462	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	115	
				FICA Taxes	37,413	Health Care Worker Background Check	12	
				Employee Health Insurance	70,797	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Inst on Public Policy	458	
				Pension	11,343	Employee Professional Fees/Dues	471	
				Other Employee Benefits	2,875	Sams Club/filing fees/Visa	100	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 17,984	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,156		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Steven Goudzwaard, Director of Finance			\$ 11,460				Yellow page advertising ()	
Jean Voss, Director of Special Projects			9,205				TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 20,665				\$ 1,156	
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
Dreyer Ooms & VanDrunen	audit & accounting		\$ 3,604	personal use of auto (Exec.Dir)		\$ 929	Out-of-State Travel	\$
Open Systems	computer software consulting		195	personal use of auto (Maint.)		374		
Paycor	payroll preparation		2,334				In-State Travel	8
Informability	computer consultants		801					
Donn Moss	Information Srv Provider		293				Seminar Expense	362
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,227	TOTAL		\$ 1,303	Entertainment Expense ()	

* 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 Tibstra House

0035196

Report Period Beginning:

7/1/12

Ending: 6/30/13

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? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 382 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,481
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? n/a Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? no
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Dreyer, Ooms, & Van Drunen Ltd
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

**TIBSTRA HOUSE
SCHEDULE OF STAFF TRAVEL
FY 2013**

	<u>TRAVEL EXPENSE</u>	<u>SEMINARS COST</u>
Staff intra-agency travel for meetings at central office, etc.		
<u>11-600-675 Allocation</u>		
7/25/2012	INR Sleep Deprivation, Autism, & ADHD Tinley Park, IL Frea Mars, Program Director	7.46
9/18/2012	Frea Mars, Administrator	0.88
1/29/2013	The ARC of IL 11th Annual QIDP Leadership Conference Alsip, IL Michelle Gabrielse, QIDP Kay Espinosa, QIDP Kathy Konrath, QIDP Peggy Mollema, QIDP Amy Tiemersma, LSCW Adam Toeset, QIDP Beth Toeset, QIDP Carla Weidenaar, QIDP	135.00 16.48
1/31/2013	INR Stress, Anxiety, & Depression Oak Brook, IL Christine Konior, DON	9.28
3/14/2013	IBP Food for Thought: How Nutrients Affect Mental Health and the Brain Oak Lawn, IL Dawn VanGroningen, RN	9.65
3/15/2013	CMI Education Institute HFS 3745 (N-4-99)	

Revolutionizing Diagnosis & Treatment Using the DSM-5
Tinley Park, IL
Amy Tiemersma, LSCW

12.09

7/24/2013 PESI Healthcare
Challenging Geriatric Behaviors
Lisle, IL
Peggy Mollema, QIDP

179.99

8.00	362.00	370.00
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Tibstra House
ID # 0035196
Schedule XX (12) Explanation of Salary Allocation
FY2013

Freya Mars	(Ln 15-1)	Program Director Salary	\$	32,685
	(Ln 10-1)	QMRP Salary	\$	10,215