

Facility Name & ID Number Eunice Smith Home

0008409 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	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	1,218	11,373	6,346	18,937	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,218	11,373	6,346	18,937	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.68%

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 12/30/1966

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 62 and days of care provided 3,972

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Eunice Smith Home

0008409

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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		142,107	186,269	328,376		328,376	313,426	641,802		1
2	Food Purchase										2
3	Housekeeping	113,543	13,124	1,199	127,866		127,866		127,866		3
4	Laundry		12,221	35,348	47,569		47,569		47,569		4
5	Heat and Other Utilities			98,033	98,033		98,033		98,033		5
6	Maintenance	44,611	11,710	74,734	131,055		131,055		131,055		6
7	Other (specify):* Cafeteria							158,580	158,580		7
8	TOTAL General Services	158,154	179,162	395,583	732,899		732,899	472,006	1,204,905		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,578,705	335,434	109,823	2,023,962		2,023,962		2,023,962		10
10a	Therapy			518,490	518,490		518,490		518,490		10a
11	Activities										11
12	Social Services	146,064	6,445	15,127	167,636		167,636	(2,150)	165,486		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,724,769	341,879	643,440	2,710,088		2,710,088	(2,150)	2,707,938		16
	C. General Administration										
17	Administrative	85,637	2,353	49,552	137,542		137,542	342,556	480,098		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	57,994			57,994		57,994		57,994		21
22	Employee Benefits & Payroll Taxes				603,340		603,340		603,340		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,297	3,297		3,297		3,297		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	143,631	2,353	52,849	802,173		802,173	342,556	1,144,729		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,026,554	523,394	1,091,872	4,245,160		4,245,160	812,412	5,057,572		29

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

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

Facility Name & ID Number

Eunice Smith Home

#0008409

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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			66,181	66,181		66,181	66,181				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			18,186	18,186		18,186	18,186				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			84,367	84,367		84,367	84,367				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			6,953	6,953		6,953	6,953				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,920	121,920		121,920	121,920				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			128,873	128,873		128,873	128,873				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,026,554	523,394	1,305,112	4,458,400		4,458,400	812,412	5,270,812			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 Eunice Smith Home

0008409

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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	(2,150)	12		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 <u>Provider Participation Fee</u>	(121,920)	42		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (124,070)		\$	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))	\$ (124,070)		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

Eunice Smith Home

ID# 0008409

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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 Eunice Smith Home# 0008409

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	313,426	0	0	0	0	0	0	0	0	0	313,426	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	158,580	0	0	0	0	0	0	0	0	0	158,580	7
8	TOTAL General Services	0	472,006	0	0	0	0	0	0	0	0	0	472,006	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	(2,150)	0	0	0	0	0	0	0	0	0	0	(2,150)	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	(2,150)	0	0	0	0	0	0	0	0	0	0	(2,150)	16
	C. General Administration													
17	Administrative	0	342,556	0	0	0	0	0	0	0	0	0	342,556	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	342,556	0	0	0	0	0	0	0	0	0	342,556	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,150)	814,562	0	0	0	0	0	0	0	0	0	812,412	29

STATE OF ILLINOIS

Facility Name & ID Number Eunice Smith Home# 0008409

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

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)	(2,150)	814,562	0	812,412	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$ 328,376	Alton Memorial Hospital		\$ 641,802	\$ 313,426	1
2	V	7 Cafeteria		Alton Memorial Hospital		158,580	158,580	2
3	V	17 Home Office Costs		BJC Health System		342,556	342,556	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		\$ 328,376			\$ 1,142,938	\$ * 814,562	14

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

Facility Name & ID Number

Eunice Smith Home

0008409

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Not Applicable								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Eunice Smith Home

0008409 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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 Alton Memorial Hospital
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	377,808	7	\$ 3,406,784	\$ 71,175	\$ 641,802	1
2	7	Cafeteria	FTE's	62,852	35	1,849,525	5,389	158,580	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,256,309	\$	\$ 800,382	25

Facility Name & ID Number

Eunice Smith Home

0008409

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Not Applicable						\$	\$			\$						
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 2013 report.		\$	<u>8,210</u>		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.)		\$	<u>18,185</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>9,975</u>		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>8,211</u>		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.		\$	<u>18,186</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>17,228</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>17,892</u>	9																
	2011	<u>17,632</u>	10																
	2012	<u>17,896</u>	11																
	2013	<u>18,185</u>	12																

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.

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 X 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Eunice Smith Home

0008409 Report Period Beginning:

01/01/2014 Ending:

12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,604 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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			1937	\$ 21,169	1
2					2
3	TOTALS			\$ 21,169	3

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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			1966	1966	\$ 433,793	\$	40	\$	\$	\$ 433,793	4
5			1968	1968	1,770		Various			1,770	5
6			1968	1968	762		Various			762	6
7			1973	1973	1,000		33			1,000	7
8			1980	1980	1,178		Various			1,178	8
	Improvement Type**										
9		A/C Units		1995	222		5			222	9
10		7/12 Ton		1981	6,888		20			6,888	10
11		Water Heater		1981	16,430		15			16,430	11
12		Sprinkler		1981	1,980		25			1,980	12
13		Painting		1985	13,850		Various			13,850	13
14		Misc Renovation		1988	75,082		15			75,082	14
15		Misc Renovation		1992	4,155		20			4,155	15
16		A/C Units		1989	16,438		15			16,438	16
17		Misc Renovation		1990	53,990		Various			53,990	17
18		Plumbing		1966	521,325		Various			521,325	18
19		Incinerator Upgrade		1973	695		5			695	19
20		Misc		1968	790		Various			790	20
21		Misc		1970	190		10			190	21
22		Incinerator Upgrade		1967	3,825		20			3,825	22
23		Parking/Wheelchair		1983	40,133		12			40,133	23
24		Driveway		1989	4,900		10			4,900	24
25		Driveway		1995	8,972		15			8,972	25
26		Fence Extension		1990	698		15			698	26
27		Parkin/Walk/Curbs		1966	47,660		Various			47,660	27
28		Misc Landscaping		1968	330		Various			330	28
29		Misc Landscaping		1970	600		Various			600	29
30		Oil & Chip Roadway		1981	3,805		5			3,805	30
31		Wall Construction		1991	5,509		20			5,509	31
32		Door Frame		1991	1,770		10			1,770	32
33		Concrete		1992	726		15			726	33
34		Patch & Seal Parking		1994	7,435		12			7,435	34
35		Door Frame		1995	1,449		10			1,449	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Install Water Softener	1995	\$ 14,149	\$	10	\$	\$	\$ 14,149	37
38	Window Treatment Lobby	1995	2,138		10			2,138	38
39	East Dining Room Carpet	1995	2,844		5			2,844	39
40	East Dining Room Alum Door	1995	1,449	72	20	72		1,404	40
41	East Dining Room Wall Covering	1995	2,845		5			2,845	41
42	Landscape	1995	42,800		15			42,800	42
43	Conference Room Renovation	1996	7,916		10			7,916	43
44	Replace Secondary Signage	1997	9,471		10			9,471	44
45	Install Vinyl Flooring Rest Rooms	1997	32,700		10			32,700	45
46	Elevator Door Protection	1997	1,656		10			1,656	46
47									47
48	Cabinetry	1997	5,816		20			5,816	48
49									49
50	Door Frame Protectors	1997	2,426		10			2,426	50
51	Interior & Exterior Lighting	1997	20,084		10			20,084	51
52	Install Vinyl Flooring Rest Rooms	1997	29,773		10			29,773	52
53	Replace Carpet East Dining Room	1998	7,927		5			7,927	53
54	Install New Transformer	1998	28,092	1,405	20	1,405		24,587	54
55	Storm Drain Back Parking Lot	1999	8,413	467	18	467		7,239	55
56	Install 4 Smoke Dampers in Basement	1999	6,248	618	15	618		6,248	56
57	Install Wandeguard Locking System	1999	2,162		7			2,162	57
58	Wall Covering & Paint	2001	8,106		5			8,106	58
59	Fire Sprinkler System	2001	193,922	7,757	25	7,757		106,042	59
60	Roof Replacement	2003	31,668		10			31,668	60
61	Air Conditioning System	2003	75,514		5			75,514	61
62	Security Camera Upgrade	2003	4,737		5			4,737	62
63	Wandeguard Door Alarm	2003	28,750		10			28,750	63
64	Air Conditioning System	2003	54,665		5			54,665	64
65	Wood Fencing Courtyard	2004	21,760		8			21,760	65
66	Landscaping	2004	21,759		10			21,759	66
67	Carpentry Work Alzheimer's Unit	2004	44,130	2,942	15	2,942		32,117	67
68	Carpentry Work Tub Room Conversion	2004	11,500	767	15	767		7,989	68
69	Carpentry Work Screen Patio West Wing	2004	19,200	1,280	15	1,280		13,013	69
70	TOTAL (lines 4 thru 69)		\$ 2,022,970	\$ 15,308		\$ 15,308	\$	\$ 1,908,655	70

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

Facility Name & ID Number Eunice Smith Home

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		\$ 2,022,970	\$ 15,308		\$ 15,308	\$	\$ 1,908,655	1
2	Metal or Wood Cabinets	2004	26,500	1,767	15	1,767		18,406	2
3	Commercial Water Heater	2004	44,917	2,570	10	2,570		44,917	3
4	Extend Floor Structure, Install Fire Dampers	2005	31,438	2,096	15	2,096		20,261	4
5	Floor Finishes- Carpet	2005	3,621		5			3,621	5
6	Fire Protection Sprinkler System	2005	3,650	146	25	146		1,411	6
7	Gazebo	2007	5,097	510	10	510		4,046	7
8	Automatic Front Door and Frame	2007	7,059		5			7,059	8
9	Wood Trim and Aluminum	2008	35,700		5			35,700	9
10	CCTV	2011	5,500	550	10	550		1,925	10
11	Smoke Barrier Upgrades	2014	23,598	2,360	10	2,360		6,686	11
12	Air Conditioning System	2014	12,800	1,280	10	1,280		1,600	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,222,850	\$ 26,587		\$ 26,587	\$	\$ 2,054,287	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	\$ 449,044	\$ 31,790	\$ 31,790	\$		\$ 348,558	71
72	Current Year Purchases	72,039	7,804	7,804			7,804	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 521,083	\$ 39,594	\$ 39,594	\$		\$ 356,362	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)	\$ 2,765,102	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,181	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,181	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)	\$ 2,410,649	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 Eunice Smith Home

0008409

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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:	<u>Not Applicable</u>			\$ _____			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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.

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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 231,798	\$		\$ 231,798	1
2	Licensed Speech and Language Development Therapist		hrs				43,956			43,956	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				242,737			242,737	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$			\$ 518,491	\$		\$ 518,491	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 Eunice Smith Home# 0008409Report Period Beginning: 01/01/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 12,844	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	14,917,591		3
4	Supply Inventory (priced at)	1,756,824		4
5	Short-Term Investments			5
6	Prepaid Insurance	61,410		6
7	Other Prepaid Expenses	201,348		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,157,163		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 18,107,180	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	177,168		13
14	Buildings, at Historical Cost	128,676,210		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	61,844,624		16
17	Accumulated Depreciation (book methods)	(122,082,260)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 68,615,742	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 86,722,922	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,509,916	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,199,293		30
31	Accrued Taxes Payable (excluding real estate taxes)	871,729		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	<u>Other Current Liabilities</u>	3,646,751		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,227,689	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Other Long Term Liabilities</u>	272,001		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 272,001	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,499,690	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 76,223,232	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 86,722,922	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 89,896,060	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 89,896,060	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	768,145	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) <u>AMH Net Loss</u>	(3,598,050)	15
16	Other (describe) <u>Change in Restricted Assets</u>	(334,467)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,164,372)	17
B. Transfers (Itemize):			
18	<u>Transfer to BJC</u>	(10,508,456)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (10,508,456)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 76,223,232	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eunice Smith Home# 0008409Report Period Beginning: 01/01/2014Ending: 12/31/2014

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	\$ 6,822,446	1
2	Discounts and Allowances for all Levels	(1,599,160)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,223,286	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	Misc Operating Revenue	3,259	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,259	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,226,545	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	732,899	31
32	Health Care	2,710,088	32
33	General Administration	802,173	33
B. Capital Expense			
34	Ownership	84,367	34
C. Ancillary Expense			
35	Special Cost Centers	6,953	35
36	Provider Participation Fee	121,920	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,458,400	40
41	Income before Income Taxes (line 30 minus line 40)**	768,145	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 768,145	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 149,682	44
45	Private Pay - Net Inpatient Revenue	2,142,208	45
46	Medicare - Net Inpatient Revenue	1,668,199	46
47	Other-(specify) <u>Managed Care</u>	1,263,197	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,223,286	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 Eunice Smith Home

0008409

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	1,917	2,080	\$ 76,630	\$ 36.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,075	14,613	441,002	30.18	3
4	Licensed Practical Nurses	15,758	17,794	365,436	20.54	4
5	CNAs & Orderlies	46,254	52,089	695,637	13.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	7,396	8,458	146,064	17.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,820	2,082	44,611	21.43	17
18	Housekeepers	8,388	9,411	113,543	12.06	18
19	Laundry					19
20	Administrator	1,851	2,076	85,637	41.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,084	3,508	57,994	16.53	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)	99,543	112,111	\$ 2,026,554 *	\$ 18.08	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

XIX-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	Not Applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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0008409

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? NA
What was the average life used for new equipment added during this period? NA
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 121,920
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NA
Attach invoices and a summary of services for all architect and appraisal fees.