

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0038208

Facility Name: ANDOVER

Address: 4636 WEST ANDOVER DRIVE PEORIA 61615
Number City Zip Code

County: PEORIA

Telephone Number: 309 691-3800 Fax # 309 689-3613

HFS ID Number:

Date of Initial License for Current Owners: 5/25/93

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 C 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: STUART SCHMITT Telephone Number: 309 691-3800
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/11 to 06/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) (Date)

(Type or Print Name) STUART SCHMITT

(Title)

Paid
Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ANDOVER# 0038208 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	16	Intermediate/DD	16	5,856	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,856	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,653			5,653	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,653			5,653	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.53%

D. How many bed-hold days during this year were paid by the Department?

7 (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?

yesG. 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 see dates of initial license

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: 6/30/12Fiscal Year: 6/30/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	3,063	1,185	6,115	10,363	38,991	49,354		49,354		1
2	Food Purchase		54,372		54,372		54,372	35	54,407		2
3	Housekeeping		4,333	1,301	5,634	5,652	11,286	723	12,009		3
4	Laundry		1,827	61	1,888		1,888		1,888		4
5	Heat and Other Utilities			18,496	18,496		18,496	1,935	20,431		5
6	Maintenance	13,500	5,338	6,995	25,833		25,833	1,827	27,660		6
7	Other (specify):*			3,440	3,440		3,440	313	3,753		7
8	TOTAL General Services	16,563	67,055	36,408	120,026	44,643	164,669	4,833	169,502		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	511,620	8,473	9,377	529,470	(44,643)	484,827		484,827		10
10a	Therapy	7,170		1,546	8,716		8,716		8,716		10a
11	Activities			1,538	1,538		1,538		1,538		11
12	Social Services	4,120			4,120		4,120		4,120		12
13	CNA Training	3,960	220	1,350	5,530		5,530	106	5,636		13
14	Program Transportation			18,394	18,394		18,394		18,394		14
15	Other (specify):*			117	117		117		117		15
16	TOTAL Health Care and Programs	526,870	8,693	32,322	567,885	(44,643)	523,242	106	523,348		16
	C. General Administration										
17	Administrative	15,537			15,537		15,537	30,245	45,782		17
18	Directors Fees										18
19	Professional Services			302	302		302	10,420	10,722		19
20	Dues, Fees, Subscriptions & Promotions			5,475	5,475		5,475	1,592	7,067		20
21	Clerical & General Office Expenses	5,638	1,631	8,685	15,954	2,873	18,827	27,040	45,867		21
22	Employee Benefits & Payroll Taxes			155,212	155,212		155,212	13,671	168,883		22
23	Inservice Training & Education										23
24	Travel and Seminar			419	419		419	12	431		24
25	Other Admin. Staff Transportation							1,172	1,172		25
26	Insurance-Prop.Liab.Malpractice			6,312	6,312		6,312	1,446	7,758		26
27	Other (specify):*			145	145		145	1,041	1,186		27
28	TOTAL General Administration	21,175	1,631	176,550	199,356	2,873	202,229	86,639	288,868		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	564,608	77,379	245,280	887,267	2,873	890,140	91,578	981,718		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			25,253	25,253		25,253	5,632	30,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,903	1,903		1,903	4,529	6,432			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,997	5,997	(2,873)	3,124	1,149	4,273			35
36	Other (specify):*											36
37	TOTAL Ownership			33,153	33,153	(2,873)	30,280	11,310	41,590			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			62,317	62,317		62,317		62,317			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			62,317	62,317		62,317		62,317			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	564,608	77,379	340,750	982,737		982,737	102,888	1,085,625			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(229)	V20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (229)		\$	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)	103,117		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 103,117		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 102,888		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.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ANDOVER

Report Period Beginning: ID# 0038208

Ending: 07/01/11

06/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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 ANDOVER # 0038208 Report Period Beginning: 07/01/11 Ending: 06/30/12

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

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

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

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.

[illegible]

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	4	5	6	7	8	
Schedule V			Cost Per General Ledger		Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
	Line	Item	Amount	Name of Related Organization					
1	V	SEE SCH. VIII	\$	PARC, Inc.		100.00%	\$ 103,117	\$ 103,117	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		\$				\$ 103,117	\$ * 103,117	14

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

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

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

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

X

NO

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

Name of Related Organization

PARC, Inc.

Street Address

1913 W. Townline Rd., P. O. Box 3418

City / State / Zip Code

Peoria, IL 61612-3418

Phone Number

(309 691-3800

Fax Number

(309 689-3613

	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	3	HOUSEKEEPING	% OF DIRECT COST	11,107,118	8	\$ 8,406	\$	955,515	\$ 723	1
2	5	HEAT & OTHER UTILITIES	% OF DIRECT COST	11,107,118	8	22,492		955,515	1,935	2
3	6	MAINTENANCE	% OF DIRECT COST	11,107,118	8	21,239	11,481	955,515	1,827	3
4	7	OTHER GENERAL SERVICES	% OF DIRECT COST	11,107,118	8	3,642		955,515	313	4
5	2	FOOD	% OF DIRECT COST	11,107,118	8	405		955,515	35	5
6	13	STAFF TRAINING	% OF DIRECT COST	11,107,118	8	1,235		955,515	106	6
7	17	ADMIN SALARIES	% OF DIRECT COST	11,107,118	8	351,575	351,575	955,515	30,245	7
8	19	PROFESSIONAL FEES	% OF DIRECT COST	11,107,118	8	121,124		955,515	10,420	8
9	20	FEES & SUBSCRIPTIONS	% OF DIRECT COST	11,107,118	8	21,166		955,515	1,821	9
10	21	CLERICAL & GENERAL	% OF DIRECT COST	11,107,118	8	314,320	262,393	955,515	27,040	10
11	22	EMPLOYEE BENEFITS/TAXES	% OF DIRECT COST	11,107,118	8	158,915		955,515	13,671	11
12	24	TRAVEL & SEMINAR	% OF DIRECT COST	11,107,118	8	145		955,515	12	12
13	25	VEHICLE COST	% OF DIRECT COST	11,107,118	8	13,624		955,515	1,172	13
14	26	INSURANCE	% OF DIRECT COST	11,107,118	8	16,804		955,515	1,446	14
15	27	MISCELLANEOUS	% OF DIRECT COST	11,107,118	8	12,099		955,515	1,041	15
16	30	DEPRECIATION	% OF DIRECT COST	11,107,118	8	65,472		955,515	5,632	16
17	32	INTEREST	% OF DIRECT COST	11,107,118	8	52,641		955,515	4,529	17
18	35	EQUIPMENT RENTAL	% OF DIRECT COST	11,107,118	8	13,359		955,515	1,149	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,198,663	\$ 625,449		\$ 103,117	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	ILLINOIS FINANCE AUTHORITY	X		BOND FINANCING OF	\$33,881.00	6/22/07	\$ 5,392,530	\$ 4,376,150	7/1/2027	4.6800	\$ 209,827	1	
2				FACILITY THAT INCLUDES								2	
3				CORPORATE OFFICES								3	
4	HEWLETT-PACKARD			Capital lease - computer equip.	\$1,634.00						1,188	4	
5	DELAGE LANDEN			Capital lease - forklift	\$540.00						474	5	
	Working Capital												
6	SOUTH SIDE BANK		X	GENERAL - LINE OF CREDIT		8/29/11	2,000,000		8/29/12	variable	12,278	6	
7							(available)			(4% floor)		7	
8												8	
9	TOTAL Facility Related				\$36,055.00		\$ 7,392,530	\$ 4,376,150			\$ 223,767	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 7,392,530	\$ 4,376,150			\$ 223,767	15	

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.)

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
ANDOVER

COUNTY
PEORIA

FACILITY IDPH LICENSE NUMBER
0038208

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()
FAX #: ()

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

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

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	10,000	B. General Construction Type:	Exterior	VINYL	Frame	WOOD	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).

NONE

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		57,880	1992	\$ 63,900	1
2					2
3	TOTALS	57,880		\$ 63,900	3

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

****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	\$ 22,094	\$ 2,555	\$ 2,555	\$	5-20	\$ 16,673	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	7,151				5-10	7,151	73
74								74
75	TOTALS	\$ 29,245	\$ 2,555	\$ 2,555	\$		\$ 23,824	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident activities &	2002 Dodge Caravan	2003	\$ 24,929	\$	\$	\$	4	\$ 24,929	76
77	care-related transport.	2000 Dodge Van	2000	30,708				4	30,708	77
78		2008 Chev. Braun Van	2008	32,564	4,070	4,070		4	32,564	78
79										79
80	TOTALS			\$ 88,201	\$ 4,070	\$ 4,070	\$		\$ 88,201	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 747,990 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,743 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,743 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)	\$ 441,446 85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

NONE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES

NO

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending

Annual Rent

12.

/2013

 \$
13.

/2014

 \$
14.

/2015

 \$

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

9. Option to Buy:

YES

NO

 Terms: *

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

15. Is Movable equipment rental included in building rental?

YES

X

 NO

16. Rental Amount for movable equipment: \$ 3,124

Description: CABLE TV

(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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☒
HOURS PER CNA60

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA60

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	1,350	\$	1,350
2	Books and Supplies		140		140
3	Classroom Wages (a)		1,980		1,980
4	Clinical Wages (b)		1,980		1,980
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		80		80
9	TOTALS	\$	5,530	\$	5,530
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,530		

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		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			\$		\$	\$		\$ NONE	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.

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	\$	1,356,346	1
2	Cash-Patient Deposits		86,539	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,428,272	3
4	Supply Inventory (priced at COST)		5,815	4
5	Short-Term Investments			5
6	Prepaid Insurance		5,209	6
7	Other Prepaid Expenses		39,335	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	2,921,516	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		835,634	12
13	Land		626,815	13
14	Buildings, at Historical Cost		7,779,199	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,572,668	16
17	Accumulated Depreciation (book methods)		(5,553,967)	17
18	Deferred Charges		144,195	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): Net assets of related entity		1,895,951	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	7,300,495	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	10,222,011	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	4,056,801	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		86,539	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		549,992	30
31	Accrued Taxes Payable (excluding real estate taxes)		78,776	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation		92,604	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	4,864,712	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		4,376,150	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Obligations under capital lease		12,003	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	4,388,153	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	9,252,865	46
47	TOTAL EQUITY(page 18, line 24)	\$ 969,146	\$ 969,146	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 969,146	\$ 10,222,011	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,067,617	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,067,617	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,034,334)	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) change in net assets of related entity	(64,137)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,098,471)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 969,146	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ANDOVER

0038208

Report Period Beginning: 07/01/11

Ending: 06/30/12

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	2	
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 1,034,466	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,034,466	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	6,898	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)	\$ 6,898	23	
D. Non-Operating Revenue			
24 Contributions	9,559	24	
25 Interest and Other Investment Income***		25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,559	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 ALLOCATION FROM SUPPORT SERVICES	8,317	28	
28a ALLOCATION FROM CENTRAL OFFICE	12,312	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,629	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,071,552	30	

	2		
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	169,502	31	
32 Health Care	523,348	32	
33 General Administration	288,868	33	
B. Capital Expense			
34 Ownership	41,590	34	
C. Ancillary Expense			
35 Special Cost Centers		35	
36 Provider Participation Fee	62,317	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,085,625	40	
41 Income before Income Taxes (line 30 minus line 40)**	(14,073)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (14,073)	43	

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,034,466	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,034,466	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? N/A 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.

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	342	389	8,099	20.82	3
4	Licensed Practical Nurses	474	539	8,673	16.09	4
5	CNAs & Orderlies	337	383	4,072	10.63	5
6	CNA Trainees	480	480	3,960	8.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	435	495	7,170	14.48	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	214	243	4,120	16.95	11
12	Dietician					12
13	Food Service Supervisor	103	117	1,589	13.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	155	176	1,474	8.38	15
16	Dishwashers					16
17	Maintenance Workers	1,057	1,201	13,500	11.24	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	535	608	15,121	24.87	20
21	Assistant Administrator					21
22	Other Administrative	738	839	14,963	17.83	22
23	Office Manager					23
24	Clerical	468	531	5,548	10.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,968	2,236	33,783	15.11	28
29	Resident Services Coordinator	3,787	4,303	48,973	11.38	29
30	Habilitation Aides (DD Homes)	31,629	35,942	393,563	10.95	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	42,722	48,482	\$ 564,608 *	\$ 11.65	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	130	\$ 6,115	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	2	142	10a-3	40
41	Occupational Therapy Consultant	16	1,404	10a-3	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)	148	\$ 7,661		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	23	686	10-3	51
52	Certified Nurse Assistants/Aides	513	8,691	10-3	52
53	TOTAL (lines 50 - 52)	536	\$ 9,377		53

STATE OF ILLINOIS

Facility Name & ID Number ANDOVER# 0038208Report Period Beginning: 07/01/11Ending: 06/30/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ERIC SUTTER	VP/COMM. LIVING	0	\$ 6,988
MIKE PREDMORE	VP/PROG. SER.	0	6,132
DORIS HAYES	VP/EDUC. SER.	0	1,365
BRET STONE	VP/MAINTENANCE	0	636
TONI SCHULTZ	PROG. DIR./COMM. LIV.	0	416
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			

B. Administrative - Other

Description	Amount
NONE	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PTC Select	Data Processing Ser.	\$ 302
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 18,189
Unemployment Compensation Insurance	2,723
FICA Taxes	45,847
Employee Health Insurance	90,578
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Retirement Plan	8,319
Life & Disability Insurance	3,227
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		\$
TOTAL		

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 0
Advertising: Employee Recruitment	506
Health Care Worker Background Check (Indicate # of checks performed 35)	568
Patient Background Checks	0
Employee Certifications	49
Membership Dues	1,211
Subscriptions	4,728
Reference Publications	5
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$ 0
In-State Travel	243
Seminar Expense	188
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 431

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NONE		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?
If YES, give association name and amount.

NO
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0 Line
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
- (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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 62,317
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

- (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?
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.

NO
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
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?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

c.

What percent of all travel expense relates to transportation of nurses and patients?

Unk.

d.

Have vehicle usage logs been maintained?

YES

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

YES
CLIFTON GUNDERSON
- (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?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A

Schedule V. - COST CENTER EXPENSES

Schedule of Reclassifications

1. \$44,643 is moved from the Nursing and Medical Records line to the Dietary and Housekeeping lines. No staff working at the residences are hired solely to perform support functions. Direct care staff are assigned responsibility for them. The reclassification is the estimated staff cost to perform dietary and housekeeping functions.
2. \$2,873 of the cost of equipment rentals for copiers and pagers is reclassified from line 35 to line 21.

Detail of costs included on Sch. V., line 7

-mowing and grounds maintenance	3,196.00
-waste disposal	244.00
Total	<u>3,440.00</u>
	=====

SCH. VII. - Other Related Business Entities	CITY	TYPE OF BUSINESS
PARC, Inc.	Peoria	Not for Profit Corp.
PARC Foundation of Central Illinois, Inc.	Peoria	Not for Profit Corp.
PARC Developmental Homes, Inc.	Peoria	Not for Profit Corp.
PARC Residential Options, Inc.	Peoria	Not for Profit Corp.
PARC Apartments Project, Inc.	Peoria	Not for Profit Corp.
PARC Community Homes, Inc.	East Peoria	Not for Profit Corp.
PARC Place, Inc.	Peoria	Not for Profit Corp.
PARC Group Home, Inc.	Peoria	Not for Profit Corp.