

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0045609</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Alhambra Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>417 East Main Bx 310</u> <u>Alhambra</u> <u>62001</u>			
NumberCityZip Code			
County: <u>Madison</u>			
Telephone Number: <u>(618) 488-3565</u> Fax # <u>(618) 488-2517</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>02/08/02</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alhambra Care Center

0045609 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	<u>11</u>	Skilled (SNF)	<u>11</u>	<u>4,026</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>73</u>	Intermediate (ICF)	<u>73</u>	<u>26,718</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>84</u>	TOTALS	<u>84</u>	<u>30,744</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>151</u>	<u>60</u>	<u>1,179</u>	<u>1,390</u>	8
9	SNF/PED					9
10	ICF	<u>13,304</u>	<u>3,930</u>		<u>17,234</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,455</u>	<u>3,990</u>	<u>1,179</u>	<u>18,624</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.58%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?
None (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 2/8/02

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/14/01 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 11 and days of care provided 1,097

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 1231
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alhambra Care Center # 0045609 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	95,205	5,045	4,464	104,714		104,714		104,714			1
2	Food Purchase		116,727		116,727		116,727	(3,674)	113,053			2
3	Housekeeping	83,791	9,986		93,777		93,777		93,777			3
4	Laundry	20,076	6,140		26,216		26,216		26,216			4
5	Heat and Other Utilities			62,121	62,121		62,121		62,121			5
6	Maintenance	11,673		34,334	46,007		46,007	(3,500)	42,507			6
7	Other (specify):* Waste Removal			2,319	2,319		2,319		2,319			7
8	TOTAL General Services	210,745	137,898	103,238	451,881		451,881	(7,174)	444,707			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	845,649	67,115	600	913,364		913,364		913,364			10
10a	Therapy											10a
11	Activities	45,260	4,268	1,236	50,764		50,764		50,764			11
12	Social Services	25,460		1,236	26,696		26,696		26,696			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	916,369	71,383	16,272	1,004,024		1,004,024		1,004,024			16
	C. General Administration											
17	Administrative	17,918			17,918		17,918		17,918			17
18	Directors Fees											18
19	Professional Services			25,536	25,536		25,536		25,536			19
20	Dues, Fees, Subscriptions & Promotions			8,808	8,808		8,808		8,808			20
21	Clerical & General Office Expenses	59,640	8,206	13,595	81,441		81,441		81,441			21
22	Employee Benefits & Payroll Taxes			246,134	246,134		246,134	(1,025)	245,109			22
23	Inservice Training & Education			45	45		45		45			23
24	Travel and Seminar			1,567	1,567		1,567		1,567			24
25	Other Admin. Staff Transportation			11,018	11,018		11,018		11,018			25
26	Insurance-Prop.Liab.Malpractice			11,569	11,569		11,569		11,569			26
27	Other (specify):*											27
28	TOTAL General Administration	77,558	8,206	318,272	404,036		404,036	(1,025)	403,011			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,204,672	217,487	437,782	1,859,941		1,859,941	(8,199)	1,851,742			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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							77,400	77,400			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,489	11,489		11,489	19,062	30,551			32
33	Real Estate Taxes			22,006	22,006		22,006		22,006			33
34	Rent-Facility & Grounds			101,567	101,567		101,567	(101,567)				34
35	Rent-Equipment & Vehicles			6,194	6,194		6,194		6,194			35
36	Other (specify):*											36
37	TOTAL Ownership			141,256	141,256		141,256	(5,105)	136,151			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,201	239,441	276,642		276,642		276,642			39
40	Barber and Beauty Shops			6,147	6,147		6,147		6,147			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,532	130,532		130,532		130,532			42
43	Other (specify):* Disallowed Costs			61,096	61,096		61,096	(61,096)				43
44	TOTAL Special Cost Centers		37,201	437,216	474,417		474,417	(61,096)	413,321			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,204,672	254,688	1,016,254	2,475,614		2,475,614	(74,400)	2,401,214			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	65,765	30		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	(353)	43		18
19	Entertainment				19
20	Contributions	(170)	43		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	(11,003)	43		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 See Page 5A	(61,332)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,093)		\$	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 Amount	2 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)	(67,307)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (67,307)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (74,400)		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 Yes	2 No	3 Amount	4 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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Disallow Related Party Interest Expense	\$ (3,563)	32	1
2	Offset Vending Income Against Expense	(1,437)	2	2
3	Offset Purchase Discounts Against Expense	(2,237)	2	3
4	Disallow Non-Care Related Costs	(3,500)	6	4
5	Disallow AP Keying Error	(1,025)	22	5
6	Disallow Loss on Sale of Asset	(49,570)	43	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	(61,332)		49

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
Demaris Weder	50	None		None		
Charles Weder	50					

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	30	Depreciation	\$	Demaris & Charles Weder	100.00%	\$ 11,635	\$ 11,635	1
2	V	32	Interest		Demaris & Charles Weder	100.00%	22,625	22,625	2
3	V	34	Rent	101,567	Demaris & Charles Weder	100.00%		(101,567)	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			\$ 101,567			\$ 34,260	\$ * (67,307)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alhambra Care Center # 0045609 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Demaris Weder	Administrator	Administration	50.00	0	40	100.00	Salary	\$ 17,918	L17, C1	1
2	Charles Weder	Office Manager	Administration	0.00	0	40	100.00	Salary	38,631	L21,C1	2
3											3
4											4
5											5
6											6
7											7
8	Note: Charles Weder is the son of Demaris and Charles Weder.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,549		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 12/31/16

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	Bank of Edwardsville		X	Building & Equipment	\$5,383.95	10/14/08	\$ 695,000	\$ 369,810	10/14/18	5.1250	\$ 21,998	1	
2	Bank of Edwardsville		X	Building & Equipment	\$862.18	12/29/11	60,000		12/29/16	5.5000	627	2	
3	Chrysler		X	Automobile	\$213.90	2/6/17	11,526	9,173	2/6/22	0.0424	240	3	
4												4	
5												5	
	Working Capital												
6	Charles Weder	X		Operating Cash	\$745.68	10/14/08	196,798	69,522	10/14/18	5.1250	3,563	6	
7	Bank of Edwardsville		X	Operating Cash	\$4,954.22	3/29/16	269,000	230,064	3/29/19	0.0400	6,742	7	
8	Bank of Edwardsville		X	Operating Cash	Interest Only	5/13/14	125,000		5/3/17	0.0425	944	8	
9	TOTAL Facility Related				\$12,159.93		\$ 1,357,324	\$ 678,569			\$ 34,114	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Disallow Related Party Interest Expense				(3,563)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,563)	14	
15	TOTALS (line 9+line14)						\$ 1,357,324	\$ 678,569			\$ 30,551	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' PREPARATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	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 2015 report.								\$	21,316	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.)								2015 \$	22,006	2
3. Under or (over) accrual (line 2 minus line 1).								\$	690	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)								\$	21,316	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.								\$	22,006	7
Real Estate Tax History:										
Real Estate Tax Bill for Calendar Year:				2011	_____ 21,357	8				
				2012	_____ 21,316	9				
				2013	_____ 21,571	10				
				2014	_____ 21,365	11				
				2015	_____ 22,006	12				
Accrual based on prior year tax bill.										

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alhambra Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0045609

CONTACT PERSON REGARDING THIS REPORT Demaris Weder

TELEPHONE (618) 488-3565 FAX #: (618) 488-2517

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 07-2-11-11-20-401-027	PEARCE W W ADD	\$ 21,509.12	\$ 21,509.12
2. 07-2-11-11-20-402-025	PEARCE W W ADD	\$ 293.24	\$ 293.24
3. 07-2-11-11-20-402-024	PEARCE W W ADD	\$ 203.36	\$ 203.36
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 22,005.72	\$ 22,005.72

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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

15,454

B. General Construction Type:

Exterior Brick

Frame

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	84 Beds	15,183		2001		\$ 14,592	1
2	See Att Sch 11A					\$ 35,344	2
3	TOTALS	15,183				\$ 49,936	3

SEE ACCOUNTANTS' PREPARATION REPORT

Land

<u>Use</u>	<u>Square Feet</u>	<u>Year Acquired</u>	<u>Cost</u>
STORAGE LOTS		2008	25,000
LAND		2012	10,344
			<u>35,344</u>

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	6		2001	1971	\$ 23,856	\$	40	\$ 596	\$ 596	\$ 8,895	4	
5	18		2001	1973	71,520		40	1,788	1,788	26,671	5	
6	24		2001	1976	119,424		40	2,986	2,986	44,536	6	
7	24		2001	1979	94,512		40	2,363	2,363	35,246	7	
8	12		2001	1983	144,096		40	3,602	3,602	53,735	8	
	Improvement Type**											
9	LEASED EQUIPMENT FROM RELATED PARTIES			2001	215,000		10			215,000	9	
10	OFFICE			1971	12,000		40	300	300	4,475	10	
11	AWNING			2002	755		15	50	50	725	11	
12	FENCE			2002	600		5			600	12	
13	TILE FLOORING			2004	2,643		20	132	132	1,652	13	
14	ROOF			2006	8,050		40	201	201	2,196	14	
15	KITCHEN CABINETS			2006	12,738		10	425	425	12,738	15	
16	DOORS/WINDOWS			2006	15,768		40	394	394	4,171	16	
17	ELECTRICAL UPGRADE			2006	1,828		40	46	46	485	17	
18	FLOORING CARPET			2006	580		10	10	10	580	18	
19	TILE FLOORING			2006	3,117		10	103	103	3,117	19	
20	EXTERIOR DOORS			2008	7,400		10	740	740	6,537	20	
21	PORCH & ELECTRICAL WIRING			2008	9,384		40	235	235	2,015	21	
22	PORCH			2010	4,625		39	119	119	802	22	
23	ROOF			2010	10,249		39	263	263	1,665	23	
24	FIRE SYSTEM			2011	60,102		39	1,541	1,541	8,155	24	
25	INSULATION OF ROOF			2011	2,096		39	54	54	319	25	
26	ROOF REPAIR			2011	2,014		39	52	52	264	26	
27	890 GALLON WATER HEATER			2011	1,800		15	120	120	600	27	
28	FIRE EXIT GATE AND REMODEL			2012	11,890		39	305	305	1,258	28	
29	DOORS/WINDOWS			2013	7,605		39	195	195	586	29	
30	ROOF REPLACEMENT			2013	32,350		39	829	829	2,626	30	
31	CARPORT			2013	673		15	45	45	134	31	
32	PLUMBING UPGRADE-DRAINAGE - A WING			2014	3,879		15	259	259	710	32	
33	ROOF REPAIR-CONNECTIONS WHERE B AND C HALL MEET			2016	4,690		20	235	235	235	33	
34											34	
35											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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alhambra Care Center

0045609

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 885,244	\$		\$ 17,988	\$ 17,988	\$ 440,728	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$406,144	\$	\$40,614	\$40,614	10	\$330,372	71
72	Current Year Purchases	12,122		1,212	1,212	10	1,212	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$418,266	\$	\$41,826	\$41,826		\$331,584	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	Maintenance	Dodge Dakota	1997	\$10,500	\$	\$1,050	\$1,050	10	\$9,538	76
77	Administrative	2017 Dodge Caravan	2016	30,026		6,005	6,005	5	6,005	77
78	Patient Care	2014 Dodge 2400 w/ Conversion	2016	52,653		10,531	10,531	5	10,531	78
79										79
80	TOTALS			\$93,179	\$	\$17,586	\$17,586		\$26,074	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)	\$1,446,625	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$77,400	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$77,400	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$798,386	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$6,194
- Description: Copy Machine-\$3,334, Postage Machine-\$576, Phone System-\$2,284
- (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	None				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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

It is the policy of this facility to only hire certified nurses aides.
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 CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
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)	\$			

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	39(3)	hrs	\$	1,082	\$ 77,894	\$	1,082	\$ 77,894	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		560	40,290		560	40,290	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,684	121,257		1,684	121,257	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				37,201		37,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,326	\$ 239,441	\$ 37,201	3,326	\$ 276,642	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 1,333	\$ 1,333	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	292,919	292,919	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,474	4,474	6
7	Other Prepaid Expenses	18,433	18,433	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 317,159	\$ 317,159	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,344	49,936	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	129,332	885,244	15
16	Equipment, at Historical Cost	588,748	511,445	16
17	Accumulated Depreciation (book methods)	(275,715)	(798,386)	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)	\$ 452,709	\$ 648,239	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 769,868	\$ 965,398	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 219,590	\$ 219,590	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	230,064	230,064	29
30	Accrued Salaries Payable	59,112	59,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	701	701	31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,316	21,316	32
33	Accrued Interest Payable	10,689	10,689	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Shareholder</u>	31,584	31,584	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 573,056	\$ 573,056	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,695	78,695	39
40	Mortgage Payable		369,810	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 78,695	\$ 448,505	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 651,751	\$ 1,021,561	46
47	TOTAL EQUITY(page 18, line 24)	\$ 118,117	\$ (56,163)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 769,868	\$ 965,398	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (179,376)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (179,376)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	297,493	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 297,493	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)	\$ 118,117	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alhambra Care Center

0045609

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,768,933	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,768,933	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	500	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 500	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income/Other Income	3,674	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,674	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,773,107	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	451,881	31
32	Health Care	1,004,024	32
33	General Administration	404,036	33
	B. Capital Expense		
34	Ownership	141,256	34
	C. Ancillary Expense		
35	Special Cost Centers	343,885	35
36	Provider Participation Fee	130,532	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,475,614	40
41	Income before Income Taxes (line 30 minus line 40)**	297,493	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 297,493	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,078,990	44
45	Private Pay - Net Inpatient Revenue	1,091,386	45
46	Medicare - Net Inpatient Revenue	598,557	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,768,933	49

Note 1 - Tax Return has not been filed at the time of filing this cost report

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

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

Tax Return? See Note 1 If not, please attach a reconciliation.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,128	2,152	\$ 54,960	\$ 25.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,929	4,993	116,664	23.37	3
4	Licensed Practical Nurses	13,761	14,165	289,881	20.46	4
5	CNAs & Orderlies	31,699	33,425	368,221	11.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,011	3,098	45,260	14.61	10
11	Social Service Workers	1,642	1,709	25,460	14.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,224	11,366	95,205	8.38	15
16	Dishwashers					16
17	Maintenance Workers	973	973	11,673	12.00	17
18	Housekeepers	7,082	7,392	83,791	11.34	18
19	Laundry	1,697	1,771	20,076	11.34	19
20	Administrator	2,160	2,160	17,918	8.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,455	2,492	59,640	23.93	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	761	820	15,923	19.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,522	86,516	\$ 1,204,672 *	\$ 13.92	34

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	96	\$ 4,464	L1,C3	35
36	Medical Director	Monthly	13,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,236	L11,C3	44
45	Social Service Consultant	24	1,236	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	144	\$ 20,736		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Alhambra Care Center

0045609

Report Period Beginning:

1/1/16

Ending:

12/31/16

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Demaris Weder		Administrator	50	\$ 17,918	Workers' Compensation Insurance		\$ 70,865	IDPH License Fee		\$	
					Unemployment Compensation Insurance		20,774	Advertising: Employee Recruitment		856	
					FICA Taxes		85,601	Health Care Worker Background Check			
					Employee Health Insurance		42,559	(Indicate # of checks performed 22)		650	
					Employee Meals			Patient Background Checks		139	
					Illinois Municipal Retirement Fund (IMRF)*			Allscripts		3,386	
					Simple Retirement Plan		23,102	Miscellaneous Dues & Subscriptions		185	
					Uniforms		2,208	Miscellaneous Licenses and Fees		3,592	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 17,918							
B. Administrative - Other											
Description			Amount					Less: Public Relations Expense		()	
N/A			\$					Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 3)				\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 245,109	TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services			Amount	Description		Line #	Amount	Description		Amount	
Vendor/Payee		Type						Out-of-State Travel		\$	
Templin Healthcare Accounting		Accounting	\$ 4,227	N/A							
MDI/Achieve		Computer Services	14,828								
Thompson Flaherty		Accounting	2,985					In-State Travel			
E-Solutions, Inc.		Computer Services	3,496								
								Seminar Expense		1,567	
								Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$	(agree to Sch. V, line 24, col. 8)			
(For legal fee disclosure, see page 39 of instructions)				\$ 25,536					TOTAL		\$ 1,567

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number <u>Alhambra Care Center</u>	STATE OF ILLINOIS # <u>0045609</u>	Report Period Beginning: <u>1/1/16</u>	Ending: <u>12/31/16</u>
--	--	---	--------------------------------

Page 22

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. N/A

(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? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 5 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,580 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 130,532
 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 benefit 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. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 20%
 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, except for Admin vehicle
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A

(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. No
 Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT