

		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: 0038208

Facility Name: ANDOVER

Address: 4636 WEST ANDOVER DR 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: 6/4/93,5/25/93,5/28/93,6/4/93

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501c3

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

In the event there are further questions about this report, please contact:
Name: STEVE ROLLINS 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 7/01/2015 to 6/30/2016 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) STEVE ROLLINS
(Title) CFO

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

#	0038208	Report Period Beginning:	7/01/2015	Ending:	6/30/2016
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D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

6/30/2016

NONE

YES

YES ☐ NO ☒

YES ☐ NO ☒

Date started SEE DATES OF INITIAL LICENSE

YES ☐ Date _____ NO ☒

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

IV. ACCOUNTING BASIS

ACCRUAL	X
---------	---

CASH*	
-------	--

CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 6/30/16 **Fiscal Year:** 6/30/16

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

	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,510			5,510	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,510			5,510	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.09%

Facility Name & ID Number **ANDOVER** # **0038208** Report Period Beginning: **7/01/2015** Ending: **6/30/2016**

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	3,193	979	5,472	9,644	36,615	46,259		46,259			1
2	Food Purchase		56,887		56,887		56,887	24	56,911			2
3	Housekeeping		1,917	1,062	2,979	5,263	8,242	272	8,514			3
4	Laundry		1,727	60	1,787		1,787		1,787			4
5	Heat and Other Utilities			17,801	17,801		17,801	1,215	19,016			5
6	Maintenance	13,679	4,781	6,240	24,700		24,700	1,081	25,781			6
7	Other (specify):*			3,754	3,754		3,754	331	4,085			7
8	TOTAL General Services	16,872	66,291	34,389	117,552	41,878	159,430	2,923	162,353			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	454,630	7,129	11,802	473,561	(41,878)	431,683		431,683			10
10a	Therapy	719			719		719		719			10a
11	Activities			1,349	1,349		1,349		1,349			11
12	Social Services	10,766			10,766		10,766		10,766			12
13	CNA Training	3,060		300	3,360		3,360	211	3,571			13
14	Program Transportation			13,770	13,770		13,770		13,770			14
15	Other (specify):*			474	474		474		474			15
16	TOTAL Health Care and Programs	469,175	7,129	27,695	503,999	(41,878)	462,121	211	462,332			16
	C. General Administration											
17	Administrative	16,758			16,758		16,758	27,313	44,071			17
18	Directors Fees											18
19	Professional Services							11,367	11,367			19
20	Dues, Fees, Subscriptions & Promotions			7,699	7,699		7,699	2,757	10,456			20
21	Clerical & General Office Expenses	8,146	1,918	5,483	15,547	2,548	18,095	29,736	47,831			21
22	Employee Benefits & Payroll Taxes			198,098	198,098		198,098	20,096	218,194			22
23	Inservice Training & Education			1,593	1,593		1,593	398	1,991			23
24	Travel and Seminar			483	483		483	328	811			24
25	Other Admin. Staff Transportation							594	594			25
26	Insurance-Prop.Liab.Malpractice			7,023	7,023		7,023	827	7,850			26
27	Other (specify):*			138	138		138	664	802			27
28	TOTAL General Administration	24,904	1,918	220,517	247,339	2,548	249,887	94,080	343,967			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	510,951	75,338	282,601	868,890	2,548	871,438	97,214	968,652			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			19,453	19,453		19,453	2,927	22,380			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,397	1,397		1,397	2,079	3,476			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,548	2,548	(2,548)		1,015	1,015			35
36	Other (specify):*											36
37	TOTAL Ownership			23,398	23,398	(2,548)	20,850	6,021	26,871			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			63,033	63,033		63,033		63,033			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			63,033	63,033		63,033		63,033			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	510,951	75,338	369,032	955,321		955,321	103,235	1,058,556			45

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

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				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)	V.20		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 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)	103,464	SCH V	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 103,464		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 103,235		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Yellow Page Advertising	\$ (229)	20	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	(229)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ANDOVER

0038208

Report Period Beginning:

 7/01/2015

Ending:

 6/30/2016

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	(229)	0	0	0	0	0	0	0	0	0	0	(229)	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	(229)	0	0	0	0	0	0	0	0	0	0	(229)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(229)	0	0	0	0	0	0	0	0	0	0	(229)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 7/01/2015 Ending: 6/30/2016

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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(229)	0	0	0	0	0	0	0	0	0	0	(229)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
EP!C, Inc.	100	none				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V		See Sch VIII	\$ 103,464	EP!C, Inc.	100.00%	\$ 103,464	\$	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			\$ 103,464			\$ 103,464	\$ *	14

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

Facility Name & ID Number

ANDOVER

0038208

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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					EP!C, Inc.	Peoria	Not for Profit Corp.	2
3					EP!C Foundation, Inc.	Peoria	Not for Profit Corp.	3
4					PARC Developmental	Peoria	Not for Profit Corp.	4
5					PARC Residential Opt	Peoria	Not for Profit Corp.	5
6					PARC Apartments Pro	Peoria	Not for Profit Corp.	6
7					PARC Community Ho	East Peoria	Not for Profit Corp.	7
8					PARC Place, Inc.	Peoria	Not for Profit Corp.	8
9					PARC Group Home, I	Peoria	Not for Profit Corp.	9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 7/01/2015 Ending: 6/30/2016

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

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 7/01/2015 Ending: 7/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization EPIC, Inc.
Street Address 1913 W. Townline Rd
City / State / Zip Code Peoria, IL 61615
Phone Number (309) 691-3800
Fax Number (309) 689-3613

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food Purchase		11,520,011	5	\$ 294	\$	924,181	\$ 24	1
2	3	Housekeeping		11,520,011	5	3,385		924,181	272	2
3	5	Heat and Other Utilities		11,520,011	5	15,147		924,181	1,215	3
4	6	Maintenance		11,520,011	5	13,476	8,502	924,181	1,081	4
5	7	Other General Services		11,520,011	5	4,121		924,181	331	5
6	13	CNA Training		11,520,011	5	2,624		924,181	211	6
7	17	Administrative		11,520,011	5	340,460	340,460	924,181	27,313	7
8	19	Professional Services		11,520,011	5	141,691		924,181	11,367	8
9	20	Dues, Fees, Subscriptions & Promotions		11,520,011	5	37,226		924,181	2,986	9
10	21	Clerical & General Office Expense		11,520,011	5	370,662	303,689	924,181	29,736	10
11	22	Employee Benefits & Payroll Taxes		11,520,011	5	250,500		924,181	20,096	11
12	23	Inservice Training & Education		11,520,011	5	4,956		924,181	398	12
13	24	Travel and Seminar		11,520,011	5	4,083		924,181	328	13
14	25	Other Admin. Staff Transportation		11,520,011	5	7,403		924,181	594	14
15	26	Insurance-Prop.Liab.Malpractice		11,520,011	5	10,307		924,181	827	15
16	27	Other		11,520,011	5	8,278		924,181	664	16
17	30	Depreciation		11,520,011	5	36,483		924,181	2,927	17
18	32	Interest		11,520,011	5	25,919		924,181	2,079	18
19	35	Rent-Equipment & Vehicles		11,520,011	5	12,653		924,181	1,015	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,289,668	\$ 652,651		\$ 103,464	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 facility that	\$33,881.00	6/22/07	\$ 5,392,530	\$ 3,490,472	7/1/2027	4.6800	\$ 169,644	1	
2				includes corporate offices								2	
3												3	
4												4	
5	U.S.Bank		x	Capital Lease - Copiers	\$2,480.25						1,019	5	
	Working Capital												
6	South Side Bank		x	Line of Credit		8/29/15	2,000,000		8/29/16	variable	235	6	
7												7	
8												8	
9	TOTAL Facility Related				\$36,361.25		\$ 7,392,530	\$ 3,490,472			\$ 170,898	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	\$ 3,490,472			\$ 170,898	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.)

FACILITY NAME ANDOVER COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0038208

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.

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

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:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1			57,880	1992	\$ 63,900	1	
2						2	
3	TOTALS		57,880		\$ 63,900	3	

Facility Name & ID Number ANDOVER

0038208

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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)		\$ 593,064	\$ 16,562		\$ 16,562	\$	\$ 391,899	70

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

XI. OWNERSHIP COSTS (continued)
C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,025	\$ 619	\$ 619	\$	5-10	\$ 4,366	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	15,475				5-20	15,475	73
74								74
75	TOTALS	\$ 20,500	\$ 619	\$ 619	\$		\$ 19,841	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 and	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 Chevy Van	2008	32,564				4	32,564	78
79										79
80	TOTALS			\$ 88,201	\$	\$	\$		\$ 88,201	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 765,665	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,181	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,181	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 499,941	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

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

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	300	\$	300
2	Books and Supplies		151		151
3	Classroom Wages (a)		1,530		1,530
4	Clinical Wages (b)		1,530		1,530
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		60		60
9	TOTALS	\$	3,571	\$	3,571
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,571		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(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	\$	857,532	1
2	Cash-Patient Deposits		85,766	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		689,330	3
4	Supply Inventory (priced at)		244	4
5	Short-Term Investments			5
6	Prepaid Insurance		51,230	6
7	Other Prepaid Expenses		42,519	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	1,726,621	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		772,221	12
13	Land		596,285	13
14	Buildings, at Historical Cost		7,731,954	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,817,897	16
17	Accumulated Depreciation (book methods)		(6,523,688)	17
18	Deferred Charges		82,520	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Net Assets of Related Entity</u>		2,026,645	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	6,503,834	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	8,230,455	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	4,972,149	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		85,766	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		524,394	30
31	Accrued Taxes Payable (excluding real estate taxes)		16,015	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation		88,392	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)	\$	5,686,716	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		3,490,472	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Capital Lease</u>		88,375	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	3,578,847	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	9,265,563	46
47	TOTAL EQUITY(page 18, line 24)	\$	(1,035,108)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	(1,035,108)	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 240,067	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 240,067	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(26,098)	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) Net Loss of all other EP!C programs	(1,249,077)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,275,175)	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)	\$ (1,035,108)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ANDOVER

0038208

Report Period Beginning: 7/01/2015

Ending: 6/30/2016

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	\$ 1,017,005	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,017,005	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	8,799	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)	\$ 8,799	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Allocation from Spt Services</u>	195	28
28a	<u>Allocation from Central Office</u>	6,459	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,654	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,032,458	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	162,353	31
32	Health Care	462,332	32
33	General Administration	343,967	33
	B. Capital Expense		
34	Ownership	26,871	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	63,033	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,058,556	40
41	Income before Income Taxes (line 30 minus line 40)**	(26,098)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (26,098)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,017,005	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)	\$ 1,017,005	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	250	284	5,908	20.80	3
4	Licensed Practical Nurses	328	372	5,772	15.52	4
5	CNAs & Orderlies	341	387	4,039	10.44	5
6	CNA Trainees	317	360	3,060	8.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	36	40	719	17.98	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	657	747	10,766	14.41	11
12	Dietician					12
13	Food Service Supervisor	108	123	1,672	13.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	160	181	1,521	8.40	15
16	Dishwashers					16
17	Maintenance Workers	1,048	1,191	13,679	11.49	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	286	326	9,814	30.10	20
21	Assistant Administrator					21
22	Other Administrative	682	776	12,674	16.33	22
23	Office Manager					23
24	Clerical	650	738	8,146	11.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,212	1,377	23,482	17.05	28
29	Resident Services Coordinator	1,722	1,957	25,300	12.93	29
30	Habilitation Aides (DD Homes)	31,702	36,025	384,399	10.67	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	39,499	44,884	\$ 510,951 *	\$ 11.38	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	96	\$ 5,472	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	96	\$ 5,472		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	42	1,511	10.3	51
52	Certified Nurse Assistants/Aides	607	10,291	10.3	52
53	TOTAL (lines 50 - 52)	649	\$ 11,802		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jeff Nelson, Eric Sutter, Autumn Ostergaard	VP, Comm. Living	0	\$ 9,624
Doris Hayes	VP, Pgm Services	0	190
Toni Schultz	Pgm. Dir./Community Living	0	5,342
Lindsay Harms	Pgm. Coordinator, Comm. Livin	0	1,602
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 16,758
B. Administrative - Other			
Description			Amount
		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
		\$	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	18,374
Unemployment Compensation Insurance			1,718
FICA Taxes			41,609
Employee Health Insurance			113,766
Employee Meals			0
Illinois Municipal Retirement Fund (IMRF)*			0
Retirement Plan Contribution			40,403
Life and Disability Insurance Benefit			2,324
TOTAL (agree to Schedule V, line 22, col.8)			\$ 218,194
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			1,613
Health Care Worker Background Check (Indicate # of checks performed)	4		221
Patient Background Checks	1		
Employee Certifications			21
Membership dues			1,252
Subscriptions			7,217
Advertising			229
Other Fees			132
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising			(229)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 10,456
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			233
Seminar Expense			578
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	811

*** Attach copy of IMRF notifications**

****See instructions.**

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? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? yes
none
- (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? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,033
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. \$ n/a Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: CliftonLarsonAllen
- (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. n/a
Attach invoices and a summary of services for all architect and appraisal fees

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Schedule V. - COST CENTER EXPENSES

Schedule of Reclassifications

- 1. \$41,878 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. \$2,548 of the cost of equipment rentals for copiers is reclassified from line 35 to line 21.

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

-mowing and grounds maintenance	2,568.00
-waste disposal	1,186.00
Total	3,754.00