

		FOR BHF USE					

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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: 0036749

Facility Name: Aviston Terrace

Address: 349 West First St Aviston 62216
Number City Zip Code

County: Clinton

Telephone Number: (618) 228-7040 Fax # (618) 228-7002

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1991

Type of Ownership:

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

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

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: 630-361-2868
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 7/1/2015 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)
(Type or Print Name) Lawrence A. Manson
(Title) Chief Executive Officer

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

0036749 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	4,498			4,498
14	TOTALS	4,498			4,498

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.81%

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 01/01/1991

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/1991 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 7/1/2015 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	15,718	1,578	1,281	18,577		18,577		18,577			1
2	Food Purchase		23,369		23,369		23,369		23,369			2
3	Housekeeping		1,029		1,029		1,029		1,029			3
4	Laundry		1,666		1,666		1,666		1,666			4
5	Heat and Other Utilities			17,234	17,234		17,234	3	17,237			5
6	Maintenance	10,673	1,294	4,472	16,439		16,439	15	16,454			6
7	Other (specify):*											7
8	TOTAL General Services	26,391	28,936	22,987	78,314		78,314	18	78,332			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	175,338	4,419	2,111	181,868		181,868		181,868			10
10a	Therapy											10a
11	Activities	53	1,629	176	1,858		1,858		1,858			11
12	Social Services			2,340	2,340		2,340		2,340			12
13	CNA Training											13
14	Program Transportation			2,307	2,307		2,307		2,307			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	175,391	6,048	8,734	190,173		190,173		190,173			16
	C. General Administration											
17	Administrative	7,667		266,374	274,041		274,041	(266,374)	7,667			17
18	Directors Fees							4,390	4,390			18
19	Professional Services			3,052	3,052		3,052	10,551	13,603			19
20	Dues, Fees, Subscriptions & Promotions			1,165	1,165		1,165	2,776	3,941			20
21	Clerical & General Office Expenses	6,673	1,705	10,308	18,686		18,686	70,451	89,137			21
22	Employee Benefits & Payroll Taxes			69,592	69,592		69,592	10,898	80,490			22
23	Inservice Training & Education			179	179		179		179			23
24	Travel and Seminar			853	853		853	1,489	2,342			24
25	Other Admin. Staff Transportation			2,324	2,324		2,324	995	3,319			25
26	Insurance-Prop.Liab.Malpractice			6,604	6,604		6,604	313	6,917			26
27	Other (specify):*											27
28	TOTAL General Administration	14,340	1,705	360,451	376,496		376,496	(164,511)	211,985			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	216,122	36,689	392,172	644,983		644,983	(164,493)	480,490			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			15,416	15,416		15,416	2,730	18,146			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,977	31,977		31,977	14,343	46,320			32
33	Real Estate Taxes			2	2		2	(2)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,019	2,019			35
36	Other (specify):*											36
37	TOTAL Ownership			47,395	47,395		47,395	19,090	66,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,046		2,046		2,046		2,046			39
40	Barber and Beauty Shops			9	9		9		9			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,949	30,949		30,949		30,949			42
43	Other (specify):* Disallowed Costs			1,236	1,236		1,236	(1,236)				43
44	TOTAL Special Cost Centers		2,046	32,194	34,240		34,240	(1,236)	33,004			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	216,122	38,735	471,761	726,618		726,618	(146,639)	579,979			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	211	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				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	(1,565)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(145,285)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,639)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (146,639)		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		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (145,612)	43	1
2	Day Program Transportation Expense	329	43	2
3	Disallow Real Estate Taxes	(2)	33	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
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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	(145,285)		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
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

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	5	Utilities	\$	Progressive Housing, Inc.	100.00%	\$ 3	\$ 3	1
2	V	6	Maintenance		Progressive Housing, Inc.	100.00%	15	15	2
3	V	17	Administrative	266,374	Progressive Housing, Inc.	100.00%		(266,374)	3
4	V	18	Director Fees		Progressive Housing, Inc.	100.00%	4,390	4,390	4
5	V	19	Professional Services		Progressive Housing, Inc.	100.00%	10,551	10,551	5
6	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	2,776	2,776	6
7	V	21	Clerical and General Office	14	Progressive Housing, Inc.	100.00%	70,465	70,451	7
8	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	10,898	10,898	8
9	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,489	1,489	9
10	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	995	995	10
11	V	26	Insurance		Progressive Housing, Inc.	100.00%	313	313	11
12	V	30	Depreciation		Progressive Housing, Inc.	100.00%	2,519	2,519	12
13	V	32	Interest	54	Progressive Housing, Inc.	100.00%	14,397	14,343	13
14	Total			\$ 266,442			\$ 118,811	\$ * (147,631)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V						\$	\$	15
16	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	2,019	2,019	16
17	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	145,612	145,612	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 147,631	\$ * 147,631	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Aviston Terrace

0036749

Report Period Beginning:

7/1/2015

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			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Steger	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop	6
7			Terra Estates-closed	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Mt Vernon	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 7/1/2015 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	Edward Childers	Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	\$ 569	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,983		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

Aviston Terrace
0036749
6/30/2016

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Cora Flota	Edward Childers	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Eileen Mullin	Misc Exp	Total
Sparta Terrace	569	569	569	569	569	569	569	405	4,390
Ellner Terrace	569	569	569	569	569	569	569	405	4,390
Taylorville Terrace	569	569	569	569	569	569	569	405	4,390
Aviston Terrace	569	569	569	569	569	569	569	405	4,390
Briarbrook Place	569	569	569	569	569	569	569	405	4,390
Harris Place	569	569	569	569	569	569	569	405	4,390
Joshua Manor	569	569	569	569	569	569	569	405	4,390
Terra Estates								157	157
Park Place	569	569	569	569	569	569	569	405	4,390
Western Gardens	249	249	249	249	249	249	249	(27)	1,713
Galaxy	284	284	284	284	284	284	284	(32)	1,957
Cardinal	284	284	284	284	284	284	284	(32)	1,957
Bill Goat Hill	284	284	284	284	284	284	284	(32)	1,957
Country Club Hill	213	213	213	213	213	213	213	151	1,643
Lee Street	213	213	213	213	213	213	213	151	1,643
Baker Street	213	213	213	213	213	213	213	151	1,643
182nd Street	213	213	213	213	213	213	213	151	1,643
Osage	213	213	213	213	213	213	213	151	1,643
Oakwood	213	213	213	213	213	213	213	151	1,643
Blair	-	-	-	-	-	-	-	318	318
Lowell	249	249	249	249	249	249	249	177	1,917
Marquette	249	249	249	249	249	249	249	177	1,917
Cherry	213	213	213	213	213	213	213	151	1,643
Luella	284	284	284	284	284	284	284	202	2,191
Olivia	249	249	249	249	249	249	249	177	1,917
Huron	213	213	213	213	213	213	213	151	1,643
Wilshire	249	249	249	249	249	249	249	177	1,917
Constance	284	284	284	284	284	284	284	193	2,182
175th Place	249	249	249	249	249	249	249	178	1,918
Sauganash	180	180	180	180	180	180	180	126	1,383
Steger	249	249	249	249	249	249	249	177	1,917
Waltonville	-	-	-	-	-	-	-	244	244
Mt. Vernon	-	-	-	-	-	-	-	388	388
Total BOD Expense	9,600	9,600	9,600	9,600	9,600	9,600	9,600	7,016	74,216

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 7/1/2015 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 Progressive Housing, Inc.
Street Address 20180 Governors Dr., Suite 300
City / State / Zip Code Olympia Fields, IL 60461
Phone Number (708) 283-1530
Fax Number (708) 283-2470

	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	5	Utilities	Bed Capacity/Specific Alloc.	270	29	47		16	\$ 3	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	270	29	258		16	15	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	270	29	74,216		16	4,390	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	270	29	180,145		16	10,551	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	270	29	49,923		16	2,776	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	270	29	1,229,303	1,076,524	16	70,465	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	270	29	193,338		16	10,898	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	270	29	27,210		16	1,489	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	270	29	17,338		16	995	9
10	26	Insurance	Bed Capacity/Specific Alloc.	270	29	7,498		16	313	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	270	29	43,850		16	2,519	11
12	32	Interest	Bed Capacity/Specific Alloc.	270	29	250,479		16	14,397	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	270	29	41,954		16	2,019	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	270	29	4,719,330		16	145,612	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,834,889	\$ 1,076,524		\$ 266,442	25

SEE ACCOUNTANTS' PREPARATION REPORT

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	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 941,465	\$ 764,464	08/15/26	6.7500	\$ 30,531	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Amortization										1,446	6	
7	Allocation from Home Office-Interest										13,669	7	
8	Allocation from Home Office-Amortization										728	8	
9	TOTAL Facility Related						\$ 941,465	\$ 764,464			\$ 46,374	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income Offset-HO				(54)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (54)	14	
15	TOTALS (line 9+line14)						\$ 941,465	\$ 764,464			\$ 46,320	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

B. Real Estate Taxes

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.

HFS 3745 (N-4-99)

FACILITY NAME	Aviston Terrace	COUNTY	Clinton
---------------	-----------------	--------	---------

CONTACT PERSON REGARDING THIS REPORT Lawrence Manson

A. Summary of Real Estate Tax Cost

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

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

C. Tax Bills

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:

3,900

B. General Construction Type:

Exterior

Brick/Siding

Frame

Wood

Number of Stories

One

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	26,400	1991	\$ 20,000	1
2	Allocated from Home Office			6,657	2
3	TOTALS	26,400		\$ 26,657	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1991	1986	\$ 432,500 *	\$ 10,413	40	\$ 10,413	\$	274,205	4
5				2012	(15,972)					(6,636)	5
6											6
7											7
8											8
	Improvement Type**										
9	Expand Bedroom			1991	1,862		15			1,862	9
10	Celing Light Fixtures			1993	536		15			536	10
11	Sprinkler System			1996	936		15			936	11
12	Sprinkler System			1998	1,274		15			1,274	12
13	Bathroom Toilets			2001	1,349		15	45	45	1,349	13
14	Bathroom Tiles			2001	2,720		15	110	110	2,720	14
15	Bathroom Tiles and Drywall			2001	2,540	169	15	169		2,524	15
16	Sprinkler System			2004	4,614	308	15	308		3,873	16
17	Sprinkler System			2004	900	60	15	60		700	17
18	Furanace Upgrade			2005	1,623	108	15	108		1,225	18
19	Ohio Valley Sprinkler Air Compressor			2005	1,994	133	15	133		1,430	19
20	New A/C			2006	1,014	11	15	68	57	684	20
21	Living Room Carpet			2007	1,185	79	15	79		744	21
22	Gazebo			2007	1,796	120	15	120		1,029	22
23	Alarm System Upgrade			2008	1,529	102	15	102		858	23
24	Concrete Sidewalk			2008	2,000	133	15	133		987	24
25	Flooring - Zickel			2010	3,731	249	15	249		1,577	25
26	New Roof (Gross of Write Off of Old Roof-See Line 5)			2012	14,919	995	15	994	(1)	3,728	26
27	Water Heater			2012	4,798	320	15	320		1,154	27
28	Install and paint new steel doors			2014	1,820	121	15	121		223	28
29	New A/C unit			2015	1,692	113	15	113		141	29
30											30
31											31
32	Allocated from Home Office				10,973			450	450		32
33											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 Aviston Terrace

0036749

Report Period Beginning:

7/1/2015

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)		\$ 482,333	\$ 13,434		\$ 14,095	\$ 661	\$ 297,123	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	\$18,227	\$1,970	\$1,970	\$	5-10 Yrs	\$14,096	71
72	Current Year Purchases	699	12	12		10 Yrs	12	72
73	Fully Depreciated Assets	21,750				5-10 Yrs	21,750	73
74	Allocated from Home Office	21,506		1,687	1,687		16,676	74
75	TOTALS	\$62,182	\$1,982	\$3,669	\$1,687		\$52,534	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	Facility Use	1998 Astro Van	2004	\$4,000	\$	\$	\$	5	\$4,000	76
77	Facility Use	Fuel Pump	2008	934				5	934	77
78	Facility Use	2008 Chrysler Van	2008	18,328				5	18,328	78
79	Allocated from Home Office			551		382	382			79
80	TOTALS			\$23,813	\$	\$382	\$382		\$23,262	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)	\$594,985	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$15,416	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$18,146	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,730	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$372,919	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: _____

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 N/A.

N/A

N/A

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: \$ 2,019 Description: Allocated from Home Office - postage machine \$88, copier \$1,257, storage \$674

(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	<u>N/A</u>		\$	\$	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. /2017 \$ _____

13. /2018 \$ _____

14. /2019 \$ _____

* 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

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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		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	39(2)	# of prescrpts				2,046		2,046	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 2,046		\$ 2,046	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	\$ 62,437	\$ 62,437	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,185)	66,165	66,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,711	5,711	7
8	Accounts Receivable (owners or related parties)	3,023	3,023	8
9	Other(specify): <u>Reserves/Deposits</u>	78,318	78,318	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 215,654	\$ 215,654	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	26,657	13
14	Buildings, at Historical Cost	39,500	482,333	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	42,241	85,995	16
17	Accumulated Depreciation (book methods)	(35,524)	(372,919)	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 (spec <u>Loan Costs</u>	5,792	5,792	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 72,009	\$ 227,858	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 287,663	\$ 443,512	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,810	\$ 16,810	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,501	24,501	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,614	1,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,292	15,292	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	16,939	16,939	36
37	<u>Deposits/Deferred Income</u>	898	898	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 76,054	\$ 76,054	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	764,464	764,464	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Bond Fund</u>	73,513	73,513	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 837,977	\$ 837,977	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 914,031	\$ 914,031	46
47	TOTAL EQUITY(page 18, line 24)	\$ (626,368)	\$ (470,519)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 287,663	\$ 443,512	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (411,372)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (411,372)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(214,996)	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)	\$ (214,996)	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)	\$ (626,368)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

0036749

Report Period Beginning: 7/1/2015

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	\$ 503,381	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 503,381	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	2,709	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,709	23
	D. Non-Operating Revenue		
24	Contributions	1,383	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,383	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	4,149	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,149	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 511,622	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	78,314	31
32	Health Care	190,173	32
33	General Administration	376,496	33
	B. Capital Expense		
34	Ownership	47,395	34
	C. Ancillary Expense		
35	Special Cost Centers	3,291	35
36	Provider Participation Fee	30,949	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 726,618	40
41	Income before Income Taxes (line 30 minus line 40)**	(214,996)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (214,996)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 503,381	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)	\$ 503,381	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 19A 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

Aviston Terrace
0036749
6/30/2016

SCH 19A

Schedule XVII
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)
and is part of a Consolidated Entity Tax Return.
Therefore, the Income or Loss cannot be
traced to the Federal Income Tax Return.

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	288	325	7,306	22.48	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants			53		10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,427	1,594	15,718	9.86	15
16	Dishwashers					16
17	Maintenance Workers	693	799	10,673	13.36	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	219	245	7,667	31.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	280	303	6,673	22.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	113	147	2,450	16.67	28
29	Resident Services Coordinator	828	874	14,766	16.89	29
30	Habilitation Aides (DD Homes)	13,488	14,311	150,816	10.54	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	17,336	18,598	\$ 216,122 *	\$ 11.62	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	24	\$ 1,281	L1, C3	35
36	Medical Director	Monthly	1,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	763	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	3	176	L11, C3	44
45	Social Service Consultant	43	2,340	L12, C3	45
46	Other(specify) <u>Dental</u>	15	1,348	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	85	\$ 7,708		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

STATE OF ILLINOIS

Facility Name & ID Number

Aviston Terrace

0036749

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

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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	
Christina Durbin		Administrator	0	\$ 7,667	Workers' Compensation Insurance		\$ 21,808	IDPH License Fee		\$	
					Unemployment Compensation Insurance		9,431	Advertising: Employee Recruitment			
					FICA Taxes		15,893	Health Care Worker Background Check			
					Employee Health Insurance		17,457	(Indicate # of checks performed 3)		105	
					Employee Meals		4,197	Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Hiring Expense		749	
					Life Insurance		268	Miscellaneous Dues & Fees		311	
					Other Employee Benefits		538				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 7,667				Allocated from Home Office		2,776	
B. Administrative - Other					Allocated from Home Office		10,898	Less: Public Relations Expense (			
Description			Amount					Non-allowable advertising (			
Allocated from Progressive Housing, Inc.			\$ 266,374					Yellow page advertising (			
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 80,490	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,941	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 266,374	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		\$
Paychex		Payroll Service	\$ 3,052		N/A						
									In-State Travel		94
									Seminar Expense		759
									Allocated from Home Office		1,489
									Entertainment Expense (		
									(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 3,052	TOTAL		\$		TOTAL		\$ 2,342

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**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
N/A
- (3)

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

No
N/A
- (4)

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

No
N/A
- (5)

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

Yes
10 Yrs
- (6)

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

\$ 1,436 Line 10
- (7)

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

Yes
- (8)

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

No
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.
- (11)

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

\$ 30,949
- (12)

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

No

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 4,197
No
Indicate the amount. \$ 0
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

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

No
N/A

c.

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

50

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

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

Yes

f.

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

Yes

g.

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

No
N/A

(17)

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

Yes

(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.
Attach invoices and a summary of services for all architect and appraisal fees

N/A

SEE ACCOUNTANTS' PREPARATION REPORT