

		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: <u>0048629</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Bryan Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2015</u> to <u>6/30/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>2150 E McCord Bx 568</u> <u>Centralia</u> <u>62801</u>																									
Number City Zip Code																									
County: <u>Marion</u>																									
Telephone Number: <u>618-918-3770</u> Fax # <u>618-532-0125</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Georgia Miller</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Emily Masching</u> <u>CFO</u></td></tr><tr><td>(Firm Name & Address) <u>CSI</u> <u>P.O. Box 1946, Centralia, IL 62801</u></td></tr><tr><td>(Telephone) <u>618-533-9633, ext 6</u> Fax # <u>618-533-6345</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Georgia Miller</u>	(Title) <u>Administrator</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Emily Masching</u> <u>CFO</u>	(Firm Name & Address) <u>CSI</u> <u>P.O. Box 1946, Centralia, IL 62801</u>	(Telephone) <u>618-533-9633, ext 6</u> Fax # <u>618-533-6345</u>												
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	(Telephone) <u>618-533-9633, ext 6</u> Fax # <u>618-533-6345</u>																								
Date of Initial License for Current Owners: <u>02/12/88</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY,NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501c3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501c3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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IRS Exemption Code <u>501c3</u>	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Emily Masching</u> Telephone Number: <u>618-533-9633, ext 6</u>																									
Email Address: _____																									

Facility Name & ID Number Bryan Manor

0048629 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	100	Intermediate/DD	100	36,600	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	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	34,914			34,914	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,914			34,914	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.39%

D. How many bed-hold days during this year were paid by the Department? 9 pd, 793 unpd (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☒ NO ☐

I. On what date did you start providing long term care at this location? Date started 09/14/2008

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 09/14/2008 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 07/1/15-06/30/16 Fiscal Year: 07/1/15-06/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Bryan Manor** # **0048629** 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	343,809	36,999	17,919	398,727		398,727		398,727			1
2	Food Purchase		265,256		265,256		265,256		265,256			2
3	Housekeeping	219,706	78,448		298,154		298,154		298,154			3
4	Laundry	122,233	36,983	223,241	382,457		382,457		382,457			4
5	Heat and Other Utilities			165,573	165,573		165,573		165,573			5
6	Maintenance	135,412	83,747	29,851	249,010		249,010		249,010			6
7	Other (specify):*											7
8	TOTAL General Services	821,160	501,433	436,584	1,759,177		1,759,177		1,759,177			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	5,368,349	518,993	77,521	5,964,863		5,964,863		5,964,863			10
10a	Therapy			70,730	70,730		70,730		70,730			10a
11	Activities	285,856	12,050		297,906		297,906		297,906			11
12	Social Services	28,443			28,443		28,443		28,443			12
13	CNA Training											13
14	Program Transportation			23,731	23,731	(14,816)	8,915		8,915			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,682,648	531,043	183,982	6,397,673	(14,816)	6,382,857		6,382,857			16
	C. General Administration											
17	Administrative	261,336			261,336		261,336		261,336			17
18	Directors Fees											18
19	Professional Services			228,955	228,955		228,955		228,955			19
20	Dues, Fees, Subscriptions & Promotions			32,745	32,745		32,745		32,745			20
21	Clerical & General Office Expenses	131,704	40,250	11,679	183,633		183,633		183,633			21
22	Employee Benefits & Payroll Taxes			1,206,098	1,206,098		1,206,098		1,206,098			22
23	Inservice Training & Education			15,464	15,464		15,464		15,464			23
24	Travel and Seminar			7,181	7,181		7,181		7,181			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			59,226	59,226		59,226		59,226			26
27	Other (specify):*											27
28	TOTAL General Administration	393,040	40,250	1,561,348	1,994,638		1,994,638		1,994,638			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,896,848	1,072,726	2,181,914	10,151,488	(14,816)	10,136,672		10,136,672			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.

PAGE 3
C. GENERAL & ADMIN
INSERVICE TRAINING AND EDUCATION

VENDOR	COST	DESCRIPTION
WAL-MART	\$ 285.56	TRAINING GAMES
RUDOLPH MUZZARELLI	\$1,920.00	TRANSPORTATION TRAINING
INSTITUTE FOR APPLIED BEHAVIORAL ANALYSIS	\$4,000.00	BEHAVIORAL ANALYSIS TRAINING - ONLINE VIDEOS
FRANCIS DIETL	\$3,290.40	HEALTH AND SAFETY TRAINING, CPR TRAINING
EXECUTIVE BUSINESS PRODUCTS	\$3,875.00	PRINTING - TRAINING MATERIALS
ALLIED 100 LLC	\$1,141.48	AED TRAINING
TRAINERS WAREHOUSE	\$ 148.63	TRAINING GAMES
FIRE EQUIPMENT SERVICE	\$ 62.34	TRAINING TABS
HR DIRECT	\$ 240.46	HARRASSMENT AND DIVERSITY TRAINING VIDEO
CARD SERVICES	\$ 500.40	FOOD AND SAFETY TRAINING, TRAINING WORKBOOKS

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			48,828	48,828		48,828	200,887	249,715			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							240,872	240,872			32
33	Real Estate Taxes			8,579	8,579		8,579	(8,579)				33
34	Rent-Facility & Grounds			432,447	432,447		432,447	(432,447)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt and Fines			18,983	18,983		18,983	(18,983)				36
37	TOTAL Ownership			508,837	508,837		508,837	(18,250)	490,587			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					14,816	14,816		14,816			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			786,100	786,100		786,100		786,100			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			786,100	786,100	14,816	800,916		800,916			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,896,848	1,072,726	3,476,851	11,446,425		11,446,425	(18,250)	11,428,175			45

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

PAGE 3-4
SCHEDULE V RECLASSIFICATION

ALL TRANSPORTATION COSTS GO INTO PROGRAM TRANSPORTATION. \$14,816
WAS RECLASSIFIED AS MEDICALLY NECESSARY BASED ON THE MILEAGE
DRIVEN FOR THOSE TRIPS.

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	(8,125)	36-3		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	(10,858)	36-3		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 Real Estate Taxes	(8,579)	33-3		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,562)		\$	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)	9,312		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 9,312		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (18,250)		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.			\$ 14,816	14-5	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)			\$ 14,816		47

Bryan Manor

ID#

0048629

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
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35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bryan Manor# 0048629

Report Period Beginning:

7/1/2015

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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

Summary B

6/30/2016

[illegible]

VII. RELATED PARTIES

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

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

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building Lease	\$ 432,447	Adult Comprehensive Human Services, Inc.	0.00%	\$	(432,447)	1
2	V	30	Depreciation		Adult Comprehensive Human Services, Inc.	0.00%	200,887	200,887	2
3	V	32	Interest		Adult Comprehensive Human Services, Inc.	0.00%	240,872	240,872	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			\$ 432,447			\$ 441,759	\$ * 9,312	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Pat Bronson	BOD						1
2	Linda O'Rourke	BOD						2
3	Sue Castleman	BOD						3
4	Karisa Neudecker	BOD						4
5	Shelly Heimann	BOD						5
6	Ryan Williams	BOD						6
7								7
8								8
9								9
10								10
11								11
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29								29
30								30

Facility Name & ID Number Bryan Manor # 0048629 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									\$		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 Bryan Manor # 0048629 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 _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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	TOTALS					\$	\$		\$	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	PNB/SEIDA		X	Mortgage/Bonds	\$36,037.25	12/26/06	\$ 6,120,000	\$ 4,634,675	12/22/2031		\$ 240,872	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$36,037.25		\$ 6,120,000	\$ 4,634,675			\$ 240,872	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,120,000	\$ 4,634,675			\$ 240,872	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	8,192	8	
		2012	8,314	9	
		2013	8,494	10	
		2014	8,579	11	
		2015		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME _____ COUNTY _____

FACILITY IDPH LICENSE NUMBER _____

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE _____ FAX #: _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,427 **B. General Construction Type:** Exterior Brick/Siding Frame Wood/Block Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building	914,760	2007	\$ 300,307	1
2					2
3	TOTALS	914,760		\$ 300,307	3

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	100		2008	2008	\$ 7,667,922	\$ 191,698	40	\$ 191,698	\$	\$ 1,501,635
5										
6										
7										
8										
	Improvement Type**									
9	Sign		2008		7,100	710	10	710		5,562
10	Sidewalk & Driveway		2009		7,198	480	15	480		3,479
11	Training Room Flooring		2013		3,553	355	10	355		947
12	Painting & Wall Repairs room 101-113, 201-203, 205		2014		19,096	955	20	955		1,910
13	207, 301-312, 402-413 & 4 parker tub rooms									
14	Painting & Wall Repairs 100 wing hallway, family room &									
15	offices in main corridor		2105		31,187	1,559	20	1,559		1,559
16	Painting & Wall Repairs 400 wing rooms, center hub restroom,									
17	housekeeping office, offices in main corridor, 300 wing, dining									
18	room, breakroom, and 100 wing		2016		56,104		20			
19	2016 Additon		2016		367,197	4,896	25	4,896		4,896
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bryan Manor

0048629

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)		\$ 8,159,357	\$ 200,653		\$ 200,653	\$	\$ 1,519,988	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	\$ 209,023	\$ 24,826	\$ 24,826	\$	5-7 years	\$ 157,390	71
72	Current Year Purchases	77,439	4,230	4,230			4,230	72
73	Fully Depreciated Assets	573,325				5-7 years	573,325	73
74								74
75	TOTALS	\$ 859,787	\$ 29,056	\$ 29,056	\$		\$ 734,945	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	Patient/Admin	2004 Ford E150XL	2014	\$ 16,000	\$ 3,200	\$ 3,200	\$	5	\$ 5,600
77	Patient/Admin	2001 Ford Bus	2012	16,005	3,201	3,201		5	12,804
78	Patient/Admin	Vans/Bus	various	114,022	7,479	7,479		5	80,107
79	Patient/Admin	2014 GMC Acadia	2015	30,628	6,126	6,126		5	6,636
80	TOTALS			\$ 176,655	\$ 20,006	\$ 20,006	\$		\$ 105,147

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	9,496,106
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	249,715
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	249,715
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,360,080

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	Improvements	\$ 393,735	\$	\$ 393,735
87	95 GMC Sierra	11,034		11,034
88	06 Mazda	11,176		11,176
89	08 Chevy Colorado	14,543		14,543
90				
91	TOTALS	\$ 430,488	\$	\$ 430,488

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: _____

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. _____/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.

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)	\$			

(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.

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	

(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
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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	\$ 911,135	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,657,481		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,861		6
7	Other Prepaid Expenses	10,212		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,591,689	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	367,197		14
15	Leasehold Improvements, at Historical Cost	503,676		15
16	Equipment, at Historical Cost	993,197		16
17	Accumulated Depreciation (book methods)	(1,105,081)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	119,837		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 878,826	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,470,515	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 149,135	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	217,938		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,356		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unclaimed Funds Payable	3,055		36
37	Day Training Payable	826,986		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,213,470	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,213,470	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,257,045	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,470,515	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,602,420	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,602,420	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,345,375)	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)	\$ (2,345,375)	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)	\$ 2,257,045	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bryan Manor

0048629

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	\$ 9,589,244	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,589,244	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	410,512	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)	\$ 410,512	23
	D. Non-Operating Revenue		
24	Contributions	12,260	24
25	Interest and Other Investment Income***	9,156	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,416	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation</u>	15,889	28
28a	<u>Miscellaneous</u>	(936,011)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (920,122)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,101,050	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,759,177	31
32	Health Care	6,405,703	32
33	General Administration	1,986,608	33
	B. Capital Expense		
34	Ownership	508,837	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	786,100	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,446,425	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,345,375)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,345,375)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,690,251	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	113,781	47
48	Other-(specify) <u>Social Security</u>	785,212	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,589,244	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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.

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SECTION I REVENUE
OTHER REVENUE

GAIN/LOSS ON SALE OF ASSETS	\$(942,161.00)
MISCELLANEOUS INCOME	<u>\$ 6,150.00</u>
	\$(936,011.00)

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,080	\$ 57,020	\$ 27.41	1
2	Assistant Director of Nursing	1,529	1,666	42,835	25.71	2
3	Registered Nurses	12,177	12,900	290,703	22.54	3
4	Licensed Practical Nurses	23,505	25,063	464,495	18.53	4
5	CNAs & Orderlies					5
6	CNA Trainees	13,715	14,960	123,420	8.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,680	1,743	45,478	26.09	9
10	Activity Assistants	17,278	18,442	240,379	13.03	10
11	Social Service Workers	1,535	1,664	28,443	17.09	11
12	Dietician					12
13	Food Service Supervisor	2,376	2,480	41,333	16.67	13
14	Head Cook	14,340	15,059	175,791	11.67	14
15	Cook Helpers/Assistants	10,163	10,933	126,687	11.59	15
16	Dishwashers					16
17	Maintenance Workers	8,033	8,383	135,412	16.15	17
18	Housekeepers	18,524	19,682	219,706	11.16	18
19	Laundry	10,816	11,663	122,233	10.48	19
20	Administrator	2,024	2,080	125,795	60.48	20
21	Assistant Administrator	1,744	1,760	46,053	26.17	21
22	Other Administrative	4,104	4,160	89,488	21.51	22
23	Office Manager					23
24	Clerical	9,214	10,380	131,704	12.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	12,757	13,949	223,413	16.02	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	291,855	307,522	4,166,460	13.55	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	459,393	486,569	\$ 6,896,848 *	\$ 14.17	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	294	\$ 17,919	1-4	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	29	2,943	10-3	39
40	Physical Therapy Consultant	108	8,096	10A-3	40
41	Occupational Therapy Consultant	750	56,264	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	121	9,110	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	6	900	10A-3	46
47	Dental, Vision, Podiatry		23,972	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,428	\$ 131,204		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	174	\$ 8,513	10-3	50
51	Licensed Practical Nurses	1,139	42,094	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,313	\$ 50,607		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
C. Hiestand	Service Coord/Training		\$ 49,491
P. McKay	HR Director		40,000
G. Miller	Admin		125,795
G. Stallard	Service Coord/Asst. Admin		46,050
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 261,336
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
CSI	Mgmt	\$	180,525
Crain, Miller, & Wernsman	Legal		18,683
Creative Systems, Inc.	IT		19,044
Glass & Shuffett, LTD	Audit		7,725
Dignan Group	Acctg		2,460
Marget Peddicord, CPA	Acctg		518
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 228,955
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	196,442
Unemployment Compensation Insurance			1,746
FICA Taxes			516,822
Employee Health Insurance			458,214
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Physicals, Vaccines, Retirement, etc.			32,874
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,206,098
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			7,573
Health Care Worker Background Check (Indicate # of checks performed)			2,713
Patient Background Checks	11		202
Dues			20,599
Subscriptions			0
License & Fees			1,658
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 32,745
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Mileage Reimbursement for seminars			685
Seminar Expense			6,496
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	7,181

*** Attach copy of IMRF notifications**

****See instructions.**

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SECTION C
LEGAL INVOICES

INVOICE DATE	LAW FIRM	ALLOWABLE AMOUNT	NON-ALLOWABLE AMOUNT	DESCRIPTION OF SERVICES
8/17/2015	CRAIN, MILLER & WERNSMAN, LTD	\$133.48	\$0.00	DISCRIMINATION
9/14/2015	CRAIN, MILLER & WERNSMAN, LTD	\$333.00	\$0.00	GENERAL - BOARD MEETING MINUTES
9/21/2015	CRAIN, MILLER & WERNSMAN, LTD	\$1,315.26	\$0.00	GUARDIANSHIPS
10/19/2015	CRAIN, MILLER & WERNSMAN, LTD	\$1,795.50	\$0.00	GUARDIANSHIPS
10/13/2015	CRAIN, MILLER & WERNSMAN, LTD	\$494.96	\$0.00	GENERAL - BOARD MEETING & AUDIT LETTER
11/16/2015	CRAIN, MILLER & WERNSMAN, LTD	\$2,424.49	\$0.00	DISCRIMINATION, MEETING MINUTES, GUARDIANSHIPS
12/21/2015	CRAIN, MILLER & WERNSMAN, LTD	\$1,310.95	\$0.00	GUARDIANSHIPS, REVIEW ANNUAL AUDIT, BOARD MEETING
1/19/2016	CRAIN, MILLER & WERNSMAN, LTD	\$1,379.71	\$0.00	RATE CHANGE, GUARDIANSHIPS
2/12/2016	CRAIN, MILLER & WERNSMAN, LTD	\$2,592.91	\$0.00	GUARDIANSHIPS, MEETING
3/21/2016	CRAIN, MILLER & WERNSMAN, LTD	\$616.55	\$0.00	GUARDIANSHIPS
4/18/2016	CRAIN, MILLER & WERNSMAN, LTD	\$5,962.07	\$0.00	GUARDIANSHIPS, GENERAL - MEETING AND REIMBURSEMENT S
6/13/2016	CRAIN, MILLER & WERNSMAN, LTD	\$323.75	\$0.00	GENERAL - MEETING

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SECTION G
TRAVEL AND SEMINAR

DATE	SEMINAR	COST	STAFF ATTENDED
7/1/2015	NURSING ASSESSMENT COURSE	\$ 120.00	EVANS, SAMANTHA WOODS, RENEE
7/31/2015	IARF 2015 CONFERENCE & EXPO	\$ 534.28	STALLARD, CARA MILLER, GEORGIA
9/21/2015	CONTINUING EDUCATION	\$ 119.00	MILLER, GEORGIA
10/19/2015	SKILLSPATH TRAINING	\$ 149.00	PIOTTER, MELINDA
10/21/2015	DEVELOPMENTAL DISABILITIES NURSES CONFERENCE	\$ 250.00	GRIMES, ALYSHIA JUENGER, NICOLE
11/16/2015	THERAP CONFERENCE	\$ 2,371.59	STALLARD, CARA SMITH, SANDRA LACEY, JESSICA MILLER, GEORGIA
12/14/2015	DD NURSING CONFERENCE	\$ 178.38	GRIMES, ALYSHIA
1/11/2016	THERAP CONFERENCE	\$ 712.00	STALLARD, CARA SMITH, SANDRA LACEY, JESSICA MILLER, GEORGIA
2/8/2016	THERAP CONFERENCE	\$ 2,062.16	STALLARD, CARA SMITH, SANDRA LACEY, JESSICA MILLER, GEORGIA

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? YES
If YES, give association name and amount. IL Assn of Rehabilitation Facilities \$20,599
- (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? YES
What was the average life used for new equipment added during this period? 5-7 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 94,549 Line 10-f
- (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. \$ 786,100
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? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 15,889
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Glass & Shuffett
- (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. YES
Attach invoices and a summary of services for all architect and appraisal fees