

		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>0041327</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Burnham House</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/15</u> to <u>9/30/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>545 Burnham</u> <u>University Park</u> <u>60466</u>																									
Number City Zip Code																									
County: <u>Will</u>																									
Telephone Number: <u>(708) 534-5529</u> Fax # <u>(217) 398-0944</u>																									
HFS ID Number: _____		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Sherry Newton</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>James B. Eisenmenger, MS, CPA</u> <u>Member</u></td></tr><tr><td>(Firm Name & Address) <u>Martin, Hood, Frieze & Associates LLC</u> <u>2507 S Neil Street, Champaign, IL 61820</u></td></tr><tr><td>(Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Sherry Newton</u>	(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>James B. Eisenmenger, MS, CPA</u> <u>Member</u>	(Firm Name & Address) <u>Martin, Hood, Frieze & Associates LLC</u> <u>2507 S Neil Street, Champaign, IL 61820</u>	(Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>													
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	(Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>																								
Date of Initial License for Current Owners: <u>05/15/1996</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 _____</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 _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ "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>Sherry Newton</u> Telephone Number: <u>(217) 398-0754</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Burnham House

0041327 Report Period Beginning: 10/1/15 Ending: 9/30/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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	5,712			5,712	13
14	TOTALS	5,712			5,712	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.54%

D. How many bed-hold days during this year were paid by the Department? 25 (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) _____

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 05/15/1996

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 12/01/1995 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 09/30/2016
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Burnham House # 0041327 Report Period Beginning: 10/1/15 Ending: 9/30/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	42,059		2,108	44,167		44,167		44,167			1
2	Food Purchase		27,481		27,481		27,481	(90)	27,391			2
3	Housekeeping	30,589	6,016		36,605		36,605	88	36,693			3
4	Laundry	26,765	1,055		27,820		27,820		27,820			4
5	Heat and Other Utilities			23,265	23,265		23,265	1,834	25,099			5
6	Maintenance			23,109	23,109		23,109	10,164	33,273			6
7	Other (specify):*											7
8	TOTAL General Services	99,413	34,552	48,482	182,447		182,447	11,996	194,443			8
	B. Health Care and Programs											
9	Medical Director		7,104	5,400	12,504		12,504	1	12,505			9
10	Nursing and Medical Records	176,604		22,004	198,608		198,608	17,597	216,205			10
10a	Therapy											10a
11	Activities	15,294	13,981		29,275		29,275		29,275			11
12	Social Services							13,124	13,124			12
13	CNA Training	8,802			8,802		8,802		8,802			13
14	Program Transportation			2,234	2,234		2,234	1,767	4,001			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	200,700	21,085	29,638	251,423		251,423	32,489	283,912			16
	C. General Administration											
17	Administrative	48,632		160,122	208,754		208,754	(97,295)	111,459			17
18	Directors Fees			4,800	4,800		4,800		4,800			18
19	Professional Services			6,505	6,505		6,505	2,252	8,757			19
20	Dues, Fees, Subscriptions & Promotions			1,695	1,695		1,695	235	1,930			20
21	Clerical & General Office Expenses	15,294	989	3,033	19,316		19,316	17,522	36,838			21
22	Employee Benefits & Payroll Taxes			51,236	51,236		51,236	20,403	71,639			22
23	Inservice Training & Education			390	390		390		390			23
24	Travel and Seminar							1,353	1,353			24
25	Other Admin. Staff Transportation			957	957		957	2,729	3,686			25
26	Insurance-Prop.Liab.Malpractice			11,166	11,166		11,166	4,151	15,317			26
27	Other (specify):*											27
28	TOTAL General Administration	63,926	989	239,904	304,819		304,819	(48,650)	256,169			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	364,039	56,626	318,024	738,689		738,689	(4,165)	734,524			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			5,394	5,394		5,394	14,689	20,083			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7	7		7	3,061	3,068			32
33	Real Estate Taxes			30,531	30,531		30,531	2,858	33,389			33
34	Rent-Facility & Grounds			92,400	92,400		92,400		92,400			34
35	Rent-Equipment & Vehicles							264	264			35
36	Other (specify):*											36
37	TOTAL Ownership			128,332	128,332		128,332	20,872	149,204			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,550	54,550		54,550		54,550			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,550	54,550		54,550		54,550			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	364,039	56,626	500,906	921,571		921,571	16,707	938,278			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				9
10	Interest and Other Investment Income	(458)	32-3		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	(90)	2-3		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (548)		\$	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 Sch. VIII	17,255		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 17,255		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 16,707		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Burnham House	
ID#	0041327
Report Period Beginning:	10/1/15
Ending:	9/30/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnham House # 0041327 Report Period Beginning: 10/1/15 Ending: 9/30/16

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burnham House # 0041327 Report Period Beginning: 10/1/15 Ending: 9/30/16

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

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C		See Attached Schedule		Health Services Consul	Champaign, IL	Consulting
				Cobblestone Rehabilita	Champaign, IL	Therapy
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate
				The Residential Develo	Champaign, IL	Long-Term Care
				Developmental Founda	Champaign, IL	Long-Term Care

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		See Schedule VIII	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Burnham House # 0041327 Report Period Beginning: 10/1/15 Ending: 9/30/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lynn Ryle	Director	Administrative	1.00	All related party wages are allocated from			Administrative	\$ 4,800	17-7	1
2					HSC. See attached allocation spreadsheet						2
3					and explanation. These individuals receive						3
4					no compensation from entities other						4
5					than HSC.						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,800		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

Facility Name & ID Number Burnham House# 0041327

Report Period Beginning:

10/1/15Ending: 9/30/16

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

Health Services Consultants, Inc.

Street Address

P.O. Box 3037

City / State / Zip Code

Champaign, IL 61826

Phone Number

(217) 398-0754

Fax Number

(217) 398-0944

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	10	Nursing	Reverse actual amounts paid and accrued to HSC for services			\$	\$		(10,169)	1
2	17	Administrative	provided in order to allocate HSC's actual expenses						(160,122)	2
3										3
4	3	Housekeeping	Beds	323	32	1,771		16	88	4
5	5	Heat & Utilities	Beds	323	32	37,019		16	1,834	5
6	6	Maintenance	Beds	323	32	194,247	125,025	16	10,164	6
7	9	Medical Director	Beds	323	32	16		16	1	7
8	10	Nursing	Beds	323	32	343,608	343,608	16	27,766	8
9	12	Social Services	Beds	323	32	264,943	264,943	16	13,124	9
10	14	Program Transportation	Beds	323	32	35,675		16	1,767	10
11	17	Administrative	Beds	323	32	920,522	857,789	16	62,827	11
12	18	Director's Fees	Beds	323	32	0		16	0	12
13	19	Professional Fees	Beds	323	32	45,459		16	2,252	13
14	20	Dues & Subscriptions	Beds	323	32	4,734		16	235	14
15	21	Clerical	Beds	323	32	353,733	271,277	16	17,522	15
16	22	P/R Taxes & Benefits	Beds	323	32	516,728		16	20,403	16
17	24	Travel & Seminar	Beds	323	32	27,322		16	1,353	17
18	25	Administrative & Transportation	Beds	323	32	55,088		16	2,729	18
19	26	Insurance	Beds	323	32	83,802		16	4,151	19
20	30	Depreciation	Beds	323	32	296,530		16	14,689	20
21	32	Interest	Beds	323	32	71,049		16	3,519	21
22	33	Real Estate Tax	Beds	323	32	57,698		16	2,858	22
23	35	Equipment Lease	Beds	323	32	5,332		16	264	23
24	N/A	Salaries & Wages	Beds			961,907	961,907	16		24
25	TOTALS					\$ 4,277,183	\$ 2,824,549		\$ 17,255	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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Busey Bank		X	Working Capital	N/A	3/7/12	N/A		9/30/14			7	6
7	Schedule VIII Allocation		X									3,519	7
8	Schedule VI Adjustment		X									(458)	8
9	TOTAL Facility Related						\$				\$	3,068	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$	3,068	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.) 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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burnham House COUNTY Will

FACILITY IDPH LICENSE NUMBER 0041327

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 21-14-12-100-022-0000		\$ 60,828.00	\$ 30,414.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5. Willow House is located on the		\$	\$
6. same tract of land. 50% of the		\$	\$
7. real estate tax is allocated to		\$	\$
8. each home.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 60,828.00	\$ 30,414.00

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? X 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:

5,200

B. General Construction Type:

Exterior

Wood

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

		1	2	3	4	
A. Land.		Use	Square Feet	Year Acquired	Cost	
1					\$	1
2						2
3	TOTALS				\$	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Furnace Inducer Motor		12/30/2003		662	24	27.5	24		306
10	Air Conditioner Condensing Unit		6/7/2004		2,300		7			2,300
11	Concrete Slab		7/29/2004		1,450		7			1,450
12	Road Repair		2/16/2005		1,263		7			1,263
13	Kitchen & Dining Flooring		2/16/2006		5,614		5			5,614
14	Control Panel-Alarm		9/13/2006		1,153		5			1,153
15	Laminate Flooring		9/30/2006		1,107		5			1,107
16	Bathroom Remodel		1/9/2007		707	26	27.5	26		254
17	Vinyl Flooring		7/10/2008		1,048		5			1,048
18	Bathroom Tile		12/14/2009		3,164		5			3,164
19	New Roof		10/18/2010		15,300	556	27.5	556		3,290
20	Tile Roofing		11/29/2010		8,172	274	5	274		8,172
21	Kitchen Cabinets/Counter Top		12/1/2010		3,619	132	27.5	132		770
22	Counter Tops		3/7/2013		765	109	7	109		392
23	Sprinkler Head Replacement		1/20/2014		3,677	134	27.5	134		357
24	Driveway Repair		1/20/2016		1,379	61	15	61		61
25	Road Repair		4/21/2016		1,150	32	15	32		32
26										26
27										27
28										28
29										29
30										30
31										31
32										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 Burnham House

0041327

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 52,530	\$ 1,348		\$ 1,348	\$	\$ 30,733	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	\$20,383	\$1,853	\$1,853	\$	5/27.5	\$3,384	71
72	Current Year Purchases	6,071	149	149		3/7/27.5	149	72
73	Fully Depreciated Assets	14,720				5/7/27.5	14,720	73
74								74
75	TOTALS	\$41,174	\$2,002	\$2,002	\$		\$18,253	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 Transportation	2004 Ford E250 Van	2004	\$41,786	\$	\$	\$	5	\$41,786	76
77	Admin. Transportation	2010 Hyundai Elantra	2010	17,578	584	584		5	17,578	77
78	Patient Transportation	2011 Ford E250 High Top Van	2010	43,747	1,460	1,460		5	43,747	78
79										79
80	TOTALS			\$103,111	\$2,044	\$2,044	\$		\$103,111	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)	\$196,815	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$5,394	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$5,394	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$152,097	85

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

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

G. Construction-in-Progress

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

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

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

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?

☒ YES

☐ NO
- If NO, see instructions.

		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:	1995	16		\$92,400	15	15	3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$92,400			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: N/A*

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

* 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

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

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)	419	2,515		2,934
4	Clinical Wages (b)	838	5,030		5,868
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 1,257	\$ 7,545	\$	\$ 8,802
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,802			

C. CONTRACTUAL INCOME

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

\$None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	9

(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		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	141,999		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 142,149	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	52,530		15
16	Equipment, at Historical Cost	144,285		16
17	Accumulated Depreciation (book methods)	(152,097)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 44,718	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 186,867	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,182		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,050		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 34,232	\$	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)	\$ 34,232	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 152,635	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 186,867	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 158,191	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 158,191	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	34,952	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)	\$ 34,952	17
	B. Transfers (Itemize):		
18	Transfers (to) from Specialized Developments, LTD	(40,508)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (40,508)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 152,635	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Burnham House

0041327

Report Period Beginning: 10/1/15

Ending:

9/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 956,065	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 956,065	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	458	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 458	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 956,523	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	182,447	31
32	Health Care	251,423	32
33	General Administration	304,819	33
	B. Capital Expense		
34	Ownership	128,332	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	54,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 921,571	40
41	Income before Income Taxes (line 30 minus line 40)**	34,952	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 34,952	43

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

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	840	840	8,802	10.48	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,460	1,460	15,294	10.48	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,095	1,095	11,471	10.48	14
15	Cook Helpers/Assistants	2,920	2,920	30,588	10.48	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,920	2,920	30,589	10.48	18
19	Laundry	2,555	2,555	26,765	10.48	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,341	2,594	48,632	18.75	22
23	Office Manager					23
24	Clerical	1,460	1,460	15,294	10.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,560	1,729	32,421	18.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	10,348	13,764	144,183	10.48	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	27,499	31,337	\$ 364,039 *	\$ 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		\$ 2,108	1-3	35
36	Medical Director		5,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		9,587	10-3	38
39	Pharmacist Consultant		790	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		260	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		3,000	10-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)		4,125	10-3	46
47	Dentist Consultant		1,219	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,489		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Alexandra Boston	Other Admin	0	\$ 28,011
Celeste Johnson	Other Admin	0	20,621
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,632
B. Administrative - Other			
Description			Amount
Management & Support Staff Fee			\$ 160,122
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 160,122
C. Professional Services			
Vendor/Payee	Type		Amount
Martin, Hood, Friese & Assoc	Accounting		\$ 3,755
Thomas, Mamer, & Haughey	Legal		122
Various	Other Professional Svcs		2,628
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,505
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 15,644
Unemployment Compensation Insurance			2,079
FICA Taxes			27,849
Employee Health Insurance			3,364
Employee Meals			1,735
Illinois Municipal Retirement Fund (IMRF)*			
Other			565
Schedule VIII Allocation			20,403
TOTAL (agree to Schedule V, line 22, col.8)			\$ 71,639
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
None			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			98
Health Care Worker Background Check (Indicate # of checks performed)			117
Patient Background Checks			
Dues & Subscriptions			1,480
Schedule VIII Allocation			235
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 1,930
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Schedule VIII Allocation			1,353
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,353

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0041327

Report Period Beginning:

10/1/15

Ending:

Page 22

9/30/16

- (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. IARF - \$1,357.72
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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
N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,550
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? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

- (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? None
- (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 benefits on Schedule V. \$ 1,735 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? Attached
- 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? None
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees