

|  |  |             |  |  |  |  |  |
|--|--|-------------|--|--|--|--|--|
|  |  | 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.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div>I. IDPH License ID Number: 0035543</div> <div>Facility Name: Carthage Terrace</div> <div>Address: 1205 N Center Street Carthage 62321</div> <div>County: Hancock</div> <div>Telephone Number: (217)357-2333 Fax #: (217)357-2013</div> <div>HFS ID Number:</div> <div>Date of Initial License for Current Owners: 09/20/89</div> <div>Type of Ownership:</div> <div><div><div><input checked="" type="checkbox"/> VOLUNTARY,NON-PROFIT</div><div><input checked="" type="checkbox"/> Charitable Corp.</div><div><input type="checkbox"/> Trust</div><div>IRS Exemption Code 501 (c) 3</div></div><div><div><input type="checkbox"/> PROPRIETARY</div><div><input type="checkbox"/> Individual</div><div><input type="checkbox"/> Partnership</div><div><input type="checkbox"/> Corporation</div><div><input type="checkbox"/> "Sub-S" Corp.</div><div><input type="checkbox"/> Limited Liability Co.</div><div><input type="checkbox"/> Trust</div><div><input type="checkbox"/> Other</div></div><div><div><input type="checkbox"/> GOVERNMENTAL</div><div><input type="checkbox"/> State</div><div><input type="checkbox"/> County</div><div><input type="checkbox"/> Other</div></div></div> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

In the event there are further questions about this report, please contact:

Name: Ron Wilson Telephone Number: (309) 343-1550

Email Address:

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carthage Terrace

# 0035543 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 | 5,517                                                       |             |       | 5,517 | 13 |
| 14 | TOTALS        | 5,517                                                       |             |       | 5,517 | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.21%

D. How many bed-hold days during this year were paid by the Department? 149 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?  
Date started 09/20/89

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 03/27/90 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐

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

Tax Year: 9/30/2016 Fiscal Year: 9/30/2016  
\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Carthage Terrace** # **0035543** 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-<br>ification<br>5 | Reclassified<br>Total<br>6 | Adjust-<br>ments<br>7 | Adjusted<br>Total<br>8 | FOR BHF USE ONLY |    |     |
|-----|------------------------------------------------------------------|--------------------------|---------------|------------|------------|----------------------------|----------------------------|-----------------------|------------------------|------------------|----|-----|
|     |                                                                  | Salary/Wage<br>1         | Supplies<br>2 | Other<br>3 | Total<br>4 |                            |                            |                       |                        | 9                | 10 |     |
|     | <b>A. General Services</b>                                       |                          |               |            |            |                            |                            |                       |                        |                  |    |     |
| 1   | Dietary                                                          | 38,281                   | 2,664         | 1,020      | 41,965     |                            | 41,965                     |                       | 41,965                 |                  |    | 1   |
| 2   | Food Purchase                                                    |                          | 44,080        |            | 44,080     |                            | 44,080                     |                       | 44,080                 |                  |    | 2   |
| 3   | Housekeeping                                                     | 21,248                   | 2,841         | 12         | 24,101     |                            | 24,101                     |                       | 24,101                 |                  |    | 3   |
| 4   | Laundry                                                          |                          | 2,658         |            | 2,658      |                            | 2,658                      |                       | 2,658                  |                  |    | 4   |
| 5   | Heat and Other Utilities                                         |                          |               | 16,219     | 16,219     |                            | 16,219                     |                       | 16,219                 |                  |    | 5   |
| 6   | Maintenance                                                      | 11,662                   | 7,278         | 9,506      | 28,446     |                            | 28,446                     | 148                   | 28,594                 |                  |    | 6   |
| 7   | Other (specify):*                                                |                          |               |            |            |                            |                            |                       |                        |                  |    | 7   |
| 8   | <b>TOTAL General Services</b>                                    | 71,191                   | 59,521        | 26,757     | 157,469    |                            | 157,469                    | 148                   | 157,617                |                  |    | 8   |
|     | <b>B. Health Care and Programs</b>                               |                          |               |            |            |                            |                            |                       |                        |                  |    |     |
| 9   | Medical Director                                                 |                          |               | 2,000      | 2,000      |                            | 2,000                      |                       | 2,000                  |                  |    | 9   |
| 10  | Nursing and Medical Records                                      | 134,849                  | 13,062        | 11,718     | 159,629    |                            | 159,629                    |                       | 159,629                |                  |    | 10  |
| 10a | Therapy                                                          |                          |               |            |            |                            |                            |                       |                        |                  |    | 10a |
| 11  | Activities                                                       |                          | 858           | 537        | 1,395      |                            | 1,395                      |                       | 1,395                  |                  |    | 11  |
| 12  | Social Services                                                  |                          |               |            |            |                            |                            |                       |                        |                  |    | 12  |
| 13  | CNA Training                                                     | 14,722                   |               |            | 14,722     |                            | 14,722                     |                       | 14,722                 |                  |    | 13  |
| 14  | Program Transportation                                           |                          |               | 6,843      | 6,843      |                            | 6,843                      |                       | 6,843                  |                  |    | 14  |
| 15  | Other (specify):*                                                |                          |               |            |            |                            |                            |                       |                        |                  |    | 15  |
| 16  | <b>TOTAL Health Care and Programs</b>                            | 149,571                  | 13,920        | 21,098     | 184,589    |                            | 184,589                    |                       | 184,589                |                  |    | 16  |
|     | <b>C. General Administration</b>                                 |                          |               |            |            |                            |                            |                       |                        |                  |    |     |
| 17  | Administrative                                                   | 14,272                   |               |            | 14,272     |                            | 14,272                     |                       | 14,272                 |                  |    | 17  |
| 18  | Directors Fees                                                   |                          |               |            |            |                            |                            | 1,036                 | 1,036                  |                  |    | 18  |
| 19  | Professional Services                                            |                          |               | 62,405     | 62,405     |                            | 62,405                     | 1,901                 | 64,306                 |                  |    | 19  |
| 20  | Dues, Fees, Subscriptions & Promotions                           |                          |               | 6,016      | 6,016      |                            | 6,016                      | 49                    | 6,065                  |                  |    | 20  |
| 21  | Clerical & General Office Expenses                               | 3,870                    | 2,493         | 3,254      | 9,617      |                            | 9,617                      | 2                     | 9,619                  |                  |    | 21  |
| 22  | Employee Benefits & Payroll Taxes                                |                          |               | 41,932     | 41,932     |                            | 41,932                     | 4                     | 41,936                 |                  |    | 22  |
| 23  | Inservice Training & Education                                   |                          |               | 5,360      | 5,360      |                            | 5,360                      | 3                     | 5,363                  |                  |    | 23  |
| 24  | Travel and Seminar                                               |                          |               | 459        | 459        |                            | 459                        |                       | 459                    |                  |    | 24  |
| 25  | Other Admin. Staff Transportation                                |                          |               | 1,927      | 1,927      |                            | 1,927                      |                       | 1,927                  |                  |    | 25  |
| 26  | Insurance-Prop.Liab.Malpractice                                  |                          |               | 5,339      | 5,339      |                            | 5,339                      | 842                   | 6,181                  |                  |    | 26  |
| 27  | Other (specify):*                                                |                          |               |            |            |                            |                            |                       |                        |                  |    | 27  |
| 28  | <b>TOTAL General Administration</b>                              | 18,142                   | 2,493         | 126,692    | 147,327    |                            | 147,327                    | 3,837                 | 151,164                |                  |    | 28  |
| 29  | <b>TOTAL Operating Expense<br/>(sum of lines 8, 16 &amp; 28)</b> | 238,904                  | 75,934        | 174,547    | 489,385    |                            | 489,385                    | 3,985                 | 493,370                |                  |    | 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                                   |                         |          | 19,996  | 19,996  |                   | 19,996             | (422)        | 19,574         |                  |    | 30 |
| 31 | Amortization of Pre-Op. & Org.                 |                         |          |         |         |                   |                    |              |                |                  |    | 31 |
| 32 | Interest                                       |                         |          |         |         |                   |                    |              |                |                  |    | 32 |
| 33 | Real Estate Taxes                              |                         |          |         |         |                   |                    |              |                |                  |    | 33 |
| 34 | Rent-Facility & Grounds                        |                         |          |         |         |                   |                    |              |                |                  |    | 34 |
| 35 | Rent-Equipment & Vehicles                      |                         |          |         |         |                   |                    |              |                |                  |    | 35 |
| 36 | Other (specify):*                              |                         |          |         |         |                   |                    |              |                |                  |    | 36 |
| 37 | TOTAL Ownership                                |                         |          | 19,996  | 19,996  |                   | 19,996             | (422)        | 19,574         |                  |    | 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                     |                         |          | 37,564  | 37,564  |                   | 37,564             |              | 37,564         |                  |    | 42 |
| 43 | Other (specify):* Disallowed Costs             |                         |          | 450     | 450     |                   | 450                | (450)        |                |                  |    | 43 |
| 44 | TOTAL Special Cost Centers                     |                         |          | 38,014  | 38,014  |                   | 38,014             | (450)        | 37,564         |                  |    | 44 |
| 45 | GRAND TOTAL COST<br>(sum of lines 29, 37 & 44) | 238,904                 | 75,934   | 232,557 | 547,395 |                   | 547,395            | 3,113        | 550,508        |                  |    | 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<br>Amount | 2<br>Refer-<br>ence | 3<br>BHF USE<br>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                                  | (422)       | 30                  |                      | 9  |
| 10 | Interest and Other Investment Income                           |             |                     |                      | 10 |
| 11 | Discounts, Allowances, Rebates & Refunds                       |             |                     |                      | 11 |
| 12 | Non-Working Officer's or Owner's Salary                        |             |                     |                      | 12 |
| 13 | Sales Tax                                                      |             |                     |                      | 13 |
| 14 | Non-Care Related Interest                                      |             |                     |                      | 14 |
| 15 | Non-Care Related Owner's Transactions                          |             |                     |                      | 15 |
| 16 | Personal Expenses (Including Transportation)                   |             |                     |                      | 16 |
| 17 | Non-Care Related Fees                                          |             |                     |                      | 17 |
| 18 | Fines and Penalties                                            |             |                     |                      | 18 |
| 19 | Entertainment                                                  |             |                     |                      | 19 |
| 20 | Contributions                                                  |             |                     |                      | 20 |
| 21 | Owner or Key-Man Insurance                                     |             |                     |                      | 21 |
| 22 | Special Legal Fees & Legal Retainers                           |             |                     |                      | 22 |
| 23 | Malpractice Insurance for Individuals                          |             |                     |                      | 23 |
| 24 | Bad Debt                                                       |             |                     |                      | 24 |
| 25 | Fund Raising, Advertising and Promotional                      | (450)       | 43                  |                      | 25 |
| 26 | Income Taxes and Illinois Personal<br>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)                              | \$ (872)    |                     | \$                   | 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<br>Amount | 2<br>Reference |    |
|----|--------------------------------------------------------------|-------------|----------------|----|
| 31 | Non-Paid Workers-Attach Schedule*                            | \$          |                | 31 |
| 32 | Donated Goods-Attach Schedule*                               |             |                | 32 |
| 33 | Amortization of Organization &<br>Pre-Operating Expense      |             |                | 33 |
| 34 | Adjustments for Related Organization<br>Costs (Schedule VII) | 3,985       |                | 34 |
| 35 | Other- Attach Schedule                                       |             |                | 35 |
| 36 | SUBTOTAL (B): (sum of lines 31-35)                           | \$ 3,985    |                | 36 |
| 37 | (sum of SUBTOTALS<br>TOTAL ADJUSTMENTS (A) and (B) )         | \$ 3,113    |                | 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<br>Yes | 2<br>No | 3<br>Amount | 4<br>Reference |    |
|----|---------------------------------|----------|---------|-------------|----------------|----|
| 38 | Medically Necessary Transport.  |          | X       | \$          |                | 38 |
| 39 |                                 |          |         |             |                | 39 |
| 40 | Gift and Coffee Shops           |          | X       |             |                | 40 |
| 41 | Barber and Beauty Shops         |          | X       |             |                | 41 |
| 42 | Laboratory and Radiology        |          | X       |             |                | 42 |
| 43 | Prescription Drugs              |          | X       |             |                | 43 |
| 44 |                                 |          |         |             |                | 44 |
| 45 | Other-Attach Schedule           |          | X       |             |                | 45 |
| 46 | Other-Attach Schedule           |          | X       |             |                | 46 |
| 47 | TOTAL (C): (sum of lines 38-46) |          |         | \$          |                | 47 |

SEE ACCOUNTANTS' PREPARATION REPORT

Carthage Terrace

|                          |         |
|--------------------------|---------|
| ID#                      | 0035543 |
| Report Period Beginning: | 10/1/15 |
| Ending:                  | 9/30/16 |

| NON-ALLOWABLE EXPENSES |       | Amount | Sch. V Line<br>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 Carthage Terrace # 0035543 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      | 148   | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 148               | 6   |
| 7   | Other (specify):*                  | 0      | 0     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0                 | 7   |
| 8   | TOTAL General Services             | 0      | 148   | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 148               | 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      | 1,036 | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 1,036             | 18  |
| 19  | Professional Services              | 0      | 1,901 | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 1,901             | 19  |
| 20  | Fees, Subscriptions & Promotions   | 0      | 49    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 49                | 20  |
| 21  | Clerical & General Office Expenses | 0      | 2     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 2                 | 21  |
| 22  | Employee Benefits & Payroll Taxes  | 0      | 4     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 4                 | 22  |
| 23  | Inservice Training & Education     | 0      | 3     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 3                 | 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      | 842   | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 842               | 26  |
| 27  | Other (specify):*                  | 0      | 0     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0                 | 27  |
| 28  | TOTAL General Administration       | 0      | 3,837 | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 3,837             | 28  |
|     | TOTAL Operating Expense            |        |       |      |      |      |      |      |      |      |      |      |                   |     |
| 29  | (sum of lines 8,16 & 28)           | 0      | 3,985 | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 3,985             | 29  |

STATE OF ILLINOIS

Summary B

Facility Name & ID Number      Carthage Terrace      #      0035543      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                                   | (422)  | 0     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | (422)             | 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                                | (422)  | 0     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | (422)             | 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):*                              | (450)  | 0     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | (450)             | 43 |
| 44 | TOTAL Special Cost Centers                     | (450)  | 0     | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | (450)             | 44 |
| 45 | GRAND TOTAL COST<br>(sum of lines 29, 37 & 44) | (872)  | 3,985 | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 3,113             | 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<br>OWNERS |             | 2<br>RELATED NURSING HOMES                       |      | 3<br>OTHER RELATED BUSINESS ENTITIES |      |                  |
|-------------|-------------|--------------------------------------------------|------|--------------------------------------|------|------------------|
| Name        | Ownership % | Name                                             | City | Name                                 | City | Type of Business |
| None        | N/A         | Community Living Options, Inc. (CLO)             |      | See Page 6 Supplemental              |      |                  |
|             |             | Unlimited Development, Inc. (CLO is sole member) |      |                                      |      |                  |
|             |             | See Page 6 Supplemental for specific homes       |      |                                      |      |                  |
|             |             |                                                  |      |                                      |      |                  |
|             |             |                                                  |      |                                      |      |                  |
|             |             |                                                  |      |                                      |      |                  |
|             |             |                                                  |      |                                      |      |                  |

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     | 6    | Maintenance                    | \$     | Community Living Options, Inc. | 100.00%              | \$ 148                                 | \$ 148                                                 | 1  |
| 2          | V     | 18   | Director Fees                  |        | Community Living Options, Inc. | 100.00%              | 1,036                                  | 1,036                                                  | 2  |
| 3          | V     | 19   | Professional Fees              |        | Community Living Options, Inc. | 100.00%              | 1,901                                  | 1,901                                                  | 3  |
| 4          | V     | 20   | Dues, Licenses and Subs        |        | Community Living Options, Inc. | 100.00%              | 49                                     | 49                                                     | 4  |
| 5          | V     | 21   | General Admin Expense          |        | Community Living Options, Inc. | 100.00%              | 2                                      | 2                                                      | 5  |
| 6          | V     | 22   | Employee Benefits              |        | Community Living Options, Inc. | 100.00%              | 4                                      | 4                                                      | 6  |
| 7          | V     | 23   | Inservice Training & Education |        | Community Living Options, Inc. | 100.00%              | 3                                      | 3                                                      | 7  |
| 8          | V     | 26   | Property/ Liability Insurance  |        | Community Living Options, Inc. | 100.00%              | 842                                    | 842                                                    | 8  |
| 9          | V     |      |                                |        |                                |                      |                                        |                                                        | 9  |
| 10         | V     |      |                                |        |                                |                      |                                        |                                                        | 10 |
| 11         | V     |      |                                |        |                                |                      |                                        |                                                        | 11 |
| 12         | V     |      |                                |        |                                |                      |                                        |                                                        | 12 |
| 13         | V     |      |                                |        |                                |                      |                                        |                                                        | 13 |
| 14         | Total |      |                                | \$     |                                |                      | \$ 3,985                               | \$ * 3,985                                             | 14 |

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Carthage Terrace

# 0035543

Report Period Beginning:

10/1/15

Ending:

9/30/16

## VII. RELATED PARTIES

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

|    | 1<br>OWNERS                    |             | 2<br>RELATED NURSING HOMES |              | 3<br>OTHER RELATED BUSINESS ENTITIES |              |                  |    |
|----|--------------------------------|-------------|----------------------------|--------------|--------------------------------------|--------------|------------------|----|
|    | Name                           | Ownership % | Name                       | City         | Name                                 | City         | Type of Business |    |
| 1  | Community Living Options, Inc. | 100%        |                            |              | Allen Court                          | Clinton      | CILA             | 1  |
| 2  | Community Living Options, Inc. | 100%        | Beardstown Terrace         | Beardstown   |                                      |              |                  | 2  |
| 3  | Community Living Options, Inc. | 100%        | Bellefontaine Place        | Waterloo     |                                      |              |                  | 3  |
| 4  | Community Living Options, Inc. | 100%        | Braun's Terrace            | Greenville   |                                      |              |                  | 4  |
| 5  | Community Living Options, Inc. | 100%        | Carthage Terrace           | Carthage     |                                      |              |                  | 5  |
| 6  | Community Living Options, Inc. | 100%        | Curtiss Court              | Springfield  |                                      |              |                  | 6  |
| 7  | Community Living Options, Inc. | 100%        | Davies Square              | Pekin        |                                      |              |                  | 7  |
| 8  | Community Living Options, Inc. | 100%        | Douglas Terrace            | Jacksonville |                                      |              |                  | 8  |
| 9  | Community Living Options, Inc. | 100%        | Edwardsville Terrace       | Edwardsville |                                      |              |                  | 9  |
| 10 | Community Living Options, Inc. | 100%        | Effingham Terrace          | Effingham    |                                      |              |                  | 10 |
| 11 | Community Living Options, Inc. | 100%        |                            |              | Eisenhower Terrace                   | Jacksonville | CILA             | 11 |
| 12 | Community Living Options, Inc. | 100%        | Freeburg Terrace           | Freeburg     |                                      |              |                  | 12 |
| 13 | Community Living Options, Inc. | 100%        | Froehlich House            | Galesburg    |                                      |              |                  | 13 |
| 14 | Community Living Options, Inc. | 100%        | Gaines Mill Place          | Springfield  |                                      |              |                  | 14 |
| 15 | Community Living Options, Inc. | 100%        | Glenwood Terrace           | Springfield  |                                      |              |                  | 15 |
| 16 | Community Living Options, Inc. | 100%        |                            |              | Hawthorne Terrace                    | Galesburg    | CILA             | 16 |
| 17 | Community Living Options, Inc. | 100%        | Highview Terrace           | Paris        |                                      |              |                  | 17 |
| 18 | Community Living Options, Inc. | 100%        | Jacksonville Group Homes:  |              |                                      |              |                  | 18 |
| 19 | Community Living Options, Inc. | 100%        | Anna Terrace               | Jacksonville |                                      |              |                  | 19 |
| 20 | Community Living Options, Inc. | 100%        | Campbell Court             | Jacksonville |                                      |              |                  | 20 |
| 21 | Community Living Options, Inc. | 100%        | LaFayette Terrace          | Jacksonville |                                      |              |                  | 21 |
| 22 | Community Living Options, Inc. | 100%        | Kepley House               | Pittsfield   |                                      |              |                  | 22 |
| 23 | Community Living Options, Inc. | 100%        | Lawrence Place             | Lincoln      |                                      |              |                  | 23 |
| 24 | Community Living Options, Inc. | 100%        | Lincoln Terrace            | Lincoln      |                                      |              |                  | 24 |
| 25 | Community Living Options, Inc. | 100%        | Maple Terrace              | Quincy       |                                      |              |                  | 25 |
| 26 | Community Living Options, Inc. | 100%        | Plonka Terrace             | Galesburg    |                                      |              |                  | 26 |
| 27 | Community Living Options, Inc. | 100%        | Quincy Terrace             | Quincy       |                                      |              |                  | 27 |
| 28 | Community Living Options, Inc. | 100%        | Schultz House              | Danville     |                                      |              |                  | 28 |
| 29 | Community Living Options, Inc. | 100%        | Stevens House              | Galesburg    |                                      |              |                  | 29 |
| 30 |                                |             |                            |              |                                      |              |                  | 30 |

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Carthage Terrace

# 0035543

Report Period Beginning:

10/1/15

Ending:

9/30/16

## VII. RELATED PARTIES

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

|    | 1<br>OWNERS                       |             | 2<br>RELATED NURSING HOMES |             | 3<br>OTHER RELATED BUSINESS ENTITIES |                   |                      |    |
|----|-----------------------------------|-------------|----------------------------|-------------|--------------------------------------|-------------------|----------------------|----|
|    | Name                              | Ownership % | Name                       | City        | Name                                 | City              | Type of Business     |    |
| 1  | Community Living Options, Inc.    | 100%        | Tanner Place               | Paris       |                                      |                   |                      | 1  |
| 2  | Community Living Options, Inc.    | 100%        | Taylor House               | Springfield |                                      |                   |                      | 2  |
| 3  | Community Living Options, Inc.    | 100%        | Thelma Terrace             | Wood River  |                                      |                   |                      | 3  |
| 4  | Community Living Options, Inc.    | 100%        | Trulson House              | Galesburg   |                                      |                   |                      | 4  |
| 5  | Community Living Options, Inc.    | 100%        | Vahle Terrace              | Jerseyville |                                      |                   |                      | 5  |
| 6  | Community Living Options, Inc.    | 100%        | Walsh Terrace              | Galesburg   |                                      |                   |                      | 6  |
| 7  | Community Living Options, Inc.    | 100%        | Wetherell Place            | Effingham   |                                      |                   |                      | 7  |
| 8  | Community Living Options, Inc.    | 100%        | Woodriver Group Homes:     |             |                                      |                   |                      | 8  |
| 9  | Community Living Options, Inc.    | 100%        | Aberdeen Terrace           | Alton       |                                      |                   |                      | 9  |
| 10 | Community Living Options, Inc.    | 100%        | Linton Terrace             | Wood River  |                                      |                   |                      | 10 |
| 11 | Community Living Options, Inc.    | 100%        | Madison Terrace            | Wood River  |                                      |                   |                      | 11 |
| 12 | Community Living Options, Inc.    | 100%        | Pershing Terrace           | Wood River  |                                      |                   |                      | 12 |
| 13 | Community Living Options, Inc.    | 100%        |                            |             | Audrey Court-CILA                    | Clinton           | CILA                 | 13 |
| 14 | Unlimited Development, Inc. (UDI) | 100%        | Parkway Manor              | Marion      |                                      |                   |                      | 14 |
| 15 | Unlimited Development, Inc. (UDI) | 100%        |                            |             | Parkway Estates                      | Marion            | Retirement living ce | 15 |
| 16 | Unlimited Development, Inc. (UDI) | 100%        | Maryville Manor            | Maryville   |                                      |                   |                      | 16 |
| 17 | Unlimited Development, Inc. (UDI) | 100%        | Shelbyville Manor          | Shelbyville |                                      |                   |                      | 17 |
| 18 | Unlimited Development, Inc. (UDI) | 100%        | Leroy Manor                | Leroy       |                                      |                   |                      | 18 |
| 19 | Unlimited Development, Inc. (UDI) | 100%        |                            |             | Liberty Estates of Car               | Carbondale        | Retirement living ce | 19 |
| 20 | Unlimited Development, Inc. (UDI) | 100%        | Care Center of Abingdon    | Abingdon    |                                      |                   |                      | 20 |
| 21 | Unlimited Development, Inc. (UDI) | 100%        | Seminary Manor             | Galesburg   |                                      |                   |                      | 21 |
| 22 | Unlimited Development, Inc. (UDI) | 100%        |                            |             | Seminary Estates                     | Galesburg         | Retirement living ce | 22 |
| 23 | Unlimited Development, Inc. (UDI) | 100%        |                            |             | Hawthorne Inn of Gal                 | Galesburg         | Assisted Living Faci | 23 |
| 24 | Unlimited Development, Inc. (UDI) | 100%        | Centralia Manor            | Centralia   |                                      |                   |                      | 24 |
| 25 | Unlimited Development, Inc. (UDI) | 100%        |                            |             | Centralia Estates                    | Centralia Estates | Retirement living ce | 25 |
| 26 | Unlimited Development, Inc. (UDI) | 100%        | Pittsfield Manor           | Pittsfield  |                                      |                   |                      | 26 |
| 27 | Unlimited Development, Inc. (UDI) | 100%        | Pekin Manor                | Pekin       |                                      |                   |                      | 27 |
| 28 | Unlimited Development, Inc. (UDI) | 100%        |                            |             | Pekin Estates                        | Pekin             | Retirement living ce | 28 |
| 29 | Unlimited Development, Inc. (UDI) | 100%        | Jerseyville Manor          | Jerseyville |                                      |                   |                      | 29 |
| 30 |                                   |             |                            |             |                                      |                   |                      | 30 |

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<br>OWNERS                       |             | 2<br>RELATED NURSING HOMES |            | 3<br>OTHER RELATED BUSINESS ENTITIES |            |                        |    |
|----|-----------------------------------|-------------|----------------------------|------------|--------------------------------------|------------|------------------------|----|
|    | Name                              | Ownership % | Name                       | City       | Name                                 | City       | Type of Business       |    |
| 1  | Unlimited Development, Inc. (UDI) | 100%        | River Hills Manor          | Keokuk, IA |                                      |            |                        | 1  |
| 2  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | River Hills Estates                  | Keokuk, IA | Retirement living ce   | 2  |
| 3  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | River Hills Inn                      | Keokuk, IA | Assisted living facili | 3  |
| 4  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Centralia East McCorn                | Galesburg  | Lessor                 | 4  |
| 5  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Galesburg North Semi                 | Galesburg  | Lessor                 | 5  |
| 6  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Jerseyville North State              | Galesburg  | Lessor                 | 6  |
| 7  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Shelbyville Route 128,               | Galesburg  | Lessor                 | 7  |
| 8  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Marion Willimason Co                 | Galesburg  | Lessor                 | 8  |
| 9  | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Leroy South Buck, LL                 | Galesburg  | Lessor                 | 9  |
| 10 | Unlimited Development, Inc. (UDI) | 100%        |                            |            | 2245 Seminary Street,                | Galesburg  | Lessor                 | 10 |
| 11 | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Pittsfield Lowry, LLC                | Galesburg  | Lessor                 | 11 |
| 12 | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Pekin El Camino, LLC                 | Galesburg  | Lessor                 | 12 |
| 13 | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Abingdon West Marti                  | Galesburg  | Lessor                 | 13 |
| 14 | Unlimited Development, Inc. (UDI) | 100%        |                            |            | Keokuk Village Circle,               | Galesburg  | Lessor                 | 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

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<br><br>Name            | 2<br><br>Title | 3<br><br>Function | 4<br><br>Ownership Interest | 5<br><br>Compensation Received From Other Nursing Homes* | 6<br><br>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week |         | 7<br><br>Compensation Included in Costs for this Reporting Period** |          | 8<br><br>Schedule V. Line & Column Reference |    |
|----|--------------------------|----------------|-------------------|-----------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------|----------|----------------------------------------------|----|
|    |                          |                |                   |                             |                                                          | Hours                                                                                  | Percent | Description                                                         | Amount   |                                              |    |
| 1  | See Attached Schedule 7A |                |                   |                             |                                                          |                                                                                        |         |                                                                     | \$ 1,036 | L18, C7                                      | 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                                                               | \$ 1,036 |                                              | 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 Carthage Terrace # 0035543 Report Period Beginning: 10/1/15 Ending: 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 Frances House, Inc.  
Street Address 285 S. Farnham  
City / State / Zip Code Galesburg, IL 61401  
Phone Number ( 309) 343-1550  
Fax Number ( 309) 343-2857

|    | 1          | 2                              | 3                        | 4           | 5               | 6              | 7                | 8        | 9                    |    |
|----|------------|--------------------------------|--------------------------|-------------|-----------------|----------------|------------------|----------|----------------------|----|
|    | Schedule V |                                | Unit of Allocation       |             | Number of       | Total Indirect | Amount of Salary | Facility | Allocation           |    |
|    | Line       | Item                           | (i.e.,Days, Direct Cost, | Total Units | Subunits Being  | Cost Being     | Cost Contained   | Units    | (col.8/col.4)x col.6 |    |
|    | Reference  |                                | Square Feet)             |             | Allocated Among | Allocated      | in Column 6      |          |                      |    |
| 1  | 6          | Maintenance                    | Bed Days Available       | 193,248     | 35              | \$ 4,884       | \$               | 5,856    | \$ 148               | 1  |
| 2  | 18         | Director Fees                  | Bed Days Available       | 193,248     | 35              | 34,193         | \$               | 5,856    | 1,036                | 2  |
| 3  | 19         | Professional Fees              | Bed Days Available       | 193,248     | 35              | 62,727         |                  | 5,856    | 1,901                | 3  |
| 4  | 20         | Dues, Licenses and Subs        | Bed Days Available       | 193,248     | 35              | 1,609          |                  | 5,856    | 49                   | 4  |
| 5  | 21         | General Admin Expense          | Bed Days Available       | 193,248     | 35              | 56             |                  | 5,856    | 2                    | 5  |
| 6  | 22         | Employee Benefits              | Bed Days Available       | 193,248     | 35              | 130            |                  | 5,856    | 4                    | 6  |
| 7  | 23         | Inservice Training & Education | Bed Days Available       | 193,248     | 35              | 90             |                  | 5,856    | 3                    | 7  |
| 8  | 26         | Property/ Liability Insurance  | Bed Days Available       | 193,248     | 35              | 27,790         |                  | 5,856    | 842                  | 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     |                                |                          |             |                 | \$ 131,479     | \$               |          | \$ 3,985             | 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  | N/A                          |           |    |                 |                          |              |                |         |               |                          |                                   |    | 2  |
| 3  |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 3  |
| 4  |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 4  |
| 5  |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 5  |
|    | Working Capital              |           |    |                 |                          |              |                |         |               |                          |                                   |    |    |
| 6  |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 6  |
| 7  |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 7  |
| 8  |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 8  |
| 9  | TOTAL Facility Related       |           |    |                 |                          |              | \$             |         | \$            |                          |                                   | \$ | 9  |
|    | B. Non-Facility Related*     |           |    |                 |                          |              |                |         |               |                          |                                   |    |    |
| 10 |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 10 |
| 11 |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 11 |
| 12 |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 12 |
| 13 |                              |           |    |                 |                          |              |                |         |               |                          |                                   |    | 13 |
| 14 | TOTAL Non-Facility Related   |           |    |                 |                          |              | \$             |         | \$            |                          |                                   | \$ | 14 |
| 15 | TOTALS (line 9+line14)       |           |    |                 |                          |              | \$             |         | \$            |                          |                                   | \$ | 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.)





|               |                  |        |         |
|---------------|------------------|--------|---------|
| FACILITY NAME | Carthage Terrace | COUNTY | Hancock |
|---------------|------------------|--------|---------|

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

### A. Summary of Real Estate Tax Cost

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

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

### C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

None

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

| 1   |          | 2           |  | 3             |  | 4         |  |
|-----|----------|-------------|--|---------------|--|-----------|--|
| Use |          | Square Feet |  | Year Acquired |  | Cost      |  |
| 1   | Facility | 70,300      |  | 1990          |  | \$ 22,692 |  |
| 2   |          |             |  |               |  |           |  |
| 3   | TOTALS   | 70,300      |  |               |  | \$ 22,692 |  |

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<br>Acquired | Year<br>Constructed | Cost       | Current Book<br>Depreciation | Life<br>in Years | Straight Line<br>Depreciation | Adjustments | Accumulated<br>Depreciation |
| 4  | 16                                              |                  | 1990             | 1989                | \$ 412,308 | \$ 14,166                    | 30               | \$ 13,744                     | \$ (422)    | \$ 365,381                  |
| 5  |                                                 |                  |                  |                     |            |                              |                  |                               |             |                             |
| 6  |                                                 |                  |                  |                     |            |                              |                  |                               |             |                             |
| 7  |                                                 |                  |                  |                     |            |                              |                  |                               |             |                             |
| 8  |                                                 |                  |                  |                     |            |                              |                  |                               |             |                             |
|    | Improvement Type**                              |                  |                  |                     |            |                              |                  |                               |             |                             |
| 9  | Garage, Parking Lot, Sidewalks, and Landscaping |                  |                  | 1989                | 30,000     |                              | 15               |                               |             | 30,000                      |
| 10 | Asphalt Paving                                  |                  |                  | 2001                | 4,370      |                              | 8                |                               |             | 4,370                       |
| 11 | Vinyl Flooring                                  |                  |                  | 2003                | 1,575      |                              | 10               |                               |             | 1,575                       |
| 12 | Vinyl Flooring                                  |                  |                  | 2004                | 1,065      |                              | 10               |                               |             | 1,065                       |
| 13 | Handrails                                       |                  |                  | 2007                | 3,772      | 250                          | 15               | 250                           |             | 2,284                       |
| 14 | New Roof                                        |                  |                  | 2007                | 9,060      | 905                          | 10               | 905                           |             | 8,154                       |
| 15 | Carpet/VCT Tile/Cove Base                       |                  |                  | 2008                | 11,985     | 1,123                        | 8                | 1,123                         |             | 11,985                      |
| 16 | Furnace/AC units                                |                  |                  | 2008                | 15,600     | 1,040                        | 15               | 1,040                         |             | 8,408                       |
| 17 |                                                 |                  |                  |                     |            |                              |                  |                               |             |                             |
| 18 |                                                 |                  |                  |                     |            |                              |                  |                               |             |                             |
| 19 |                                                 |                  |                  |                     |            |                              |                  |                               |             |                             |
| 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  
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Carthage Terrace

# 0035543

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<br>Improvement Type** |                         | 3<br>Year<br>Constructed | 4<br>Cost  | 5<br>Current Book<br>Depreciation | 6<br>Life<br>in Years | 7<br>Straight Line<br>Depreciation | 8<br>Adjustments | 9<br>Accumulated<br>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) |                          | \$ 489,735 | \$ 17,484                         |                       | \$ 17,062                          | \$ (422)         | \$ 433,222                       | 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<br>Cost | Current Book Depreciation 2 | Straight Line Depreciation 3 | 4<br>Adjustments | Component Life 5 | Accumulated Depreciation 6 |    |
|----|--------------------------|-----------|-----------------------------|------------------------------|------------------|------------------|----------------------------|----|
| 71 | Purchased in Prior Years | \$67,281  | \$2,138                     | \$2,138                      | \$               | 3-15 yrs         | \$51,353                   | 71 |
| 72 | Current Year Purchases   | 2,490     | 374                         | 374                          |                  | 5 yrs            | 374                        | 72 |
| 73 | Fully Depreciated Assets |           |                             |                              |                  |                  |                            | 73 |
| 74 |                          |           |                             |                              |                  |                  |                            | 74 |
| 75 | TOTALS                   | \$69,771  | \$2,512                     | \$2,512                      | \$               |                  | \$51,727                   | 75 |

D. Vehicle Costs. (See instructions.)\*

|    | 1<br>Use     | Model, Make and Year 2   | Year Acquired 3 | 4<br>Cost | Current Book Depreciation 5 | Straight Line Depreciation 6 | 7<br>Adjustments | Life in Years 8 | Accumulated Depreciation 9 |    |
|----|--------------|--------------------------|-----------------|-----------|-----------------------------|------------------------------|------------------|-----------------|----------------------------|----|
| 76 | Patient Care | 2007 Ford E350 Van Terra | 2007            | \$45,000  |                             |                              | \$               | 4               | \$45,000                   | 76 |
| 77 |              |                          |                 |           |                             |                              |                  |                 |                            | 77 |
| 78 |              |                          |                 |           |                             |                              |                  |                 |                            | 78 |
| 79 |              |                          |                 |           |                             |                              |                  |                 |                            | 79 |
| 80 | TOTALS       |                          |                 | \$45,000  | \$                          | \$                           | \$               |                 | \$45,000                   | 80 |

E. Summary of Care-Related Assets

|    | 1                                                                                                                              | 2         |    |
|----|--------------------------------------------------------------------------------------------------------------------------------|-----------|----|
|    | Reference                                                                                                                      | Amount    |    |
| 81 | Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable) | \$627,198 | 81 |
| 82 | Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)             | \$19,996  | 82 |
| 83 | Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)            | \$19,574  | 83 |
| 84 | Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)                           | \$(422)   | 84 |
| 85 | Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)              | \$529,949 | 85 |

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

|    | 1<br>Description & Year Acquired | 2<br>Cost | Current Book Depreciation 3 | Accumulated Depreciation 4 |    |
|----|----------------------------------|-----------|-----------------------------|----------------------------|----|
| 86 | N/A                              | \$        | \$                          | \$                         | 86 |
| 87 |                                  |           |                             |                            | 87 |
| 88 |                                  |           |                             |                            | 88 |
| 89 |                                  |           |                             |                            | 89 |
| 90 |                                  |           |                             |                            | 90 |
| 91 | TOTALS                           | \$        | \$                          | \$                         | 91 |

G. Construction-in-Progress

|    | Description | Cost |    |
|----|-------------|------|----|
| 92 | N/A         | \$   | 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:

N/A- Facility Owned
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.

YESNO

|   |                    | 1<br>Year<br>Constructed | 2<br>Number<br>of Beds | 3<br>Original<br>Lease Date | 4<br>Rental<br>Amount | 5<br>Total Years<br>of Lease | 6<br>Total Years<br>Renewal Option* |   |
|---|--------------------|--------------------------|------------------------|-----------------------------|-----------------------|------------------------------|-------------------------------------|---|
| 3 | Original Building: |                          |                        |                             | \$                    |                              |                                     | 3 |
| 4 | Additions          |                          |                        |                             |                       |                              |                                     | 4 |
| 5 |                    |                          |                        |                             |                       |                              |                                     | 5 |
| 6 |                    |                          |                        |                             |                       |                              |                                     | 6 |
| 7 | TOTAL              |                          |                        |                             | \$                    |                              |                                     | 7 |

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

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

N/AN/A
9. Option to Buy:

YESNO

 Terms: 

N/A

\*

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$0

Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

|    | 1<br>Use | 2<br>Model Year<br>and Make | 3<br>Monthly Lease<br>Payment | 4<br>Rental Expense<br>for this Period |    |
|----|----------|-----------------------------|-------------------------------|----------------------------------------|----|
| 17 |          |                             | \$                            | \$                                     | 17 |
| 18 | N/A      |                             |                               |                                        | 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

☒

☐

☐

138

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)             |           | 14,722    |          | 14,722    |
| 4  | Clinical Wages (b)              |           |           |          |           |
| 5  | In-House Trainer Wages (c)      |           |           |          |           |
| 6  | Transportation                  |           |           |          |           |
| 7  | Contractual Payments            |           |           |          |           |
| 8  | CNA Competency Tests            |           |           |          |           |
| 9  | TOTALS                          | \$        | \$ 14,722 | \$       | \$ 14,722 |
| 10 | SUM OF line 9, col. 1 and 2 (e) | \$ 14,722 |           |          |           |

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        | 7 |
| 2. From other facilities (f) |   |
| DROP-OUTS                    |   |
| 1. From this facility        |   |
| 2. From other facilities (f) |   |
| TOTAL TRAINED                | 7 |

(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<br>Line & Column<br>Reference | Staff               |      | Outside Practitioner<br>(other than consultant) |      | Supplies<br>(Actual or<br>Allocated) | Total Units<br>(Column 2 + 4) | Total Cost<br>(Col. 3 + 5 + 6) |    |
|    |                                                                                |                                          | Units of<br>Service | Cost | Units                                           | Cost |                                      |                               |                                |    |
| 1  | Licensed Occupational Therapist                                                |                                          | hrs                 | \$   |                                                 | \$   | \$                                   |                               | \$                             | 1  |
| 2  | Licensed Speech and Language<br>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<br>prescrpts   |      |                                                 |      |                                      |                               |                                | 9  |
| 10 | Psychological Services<br>(Evaluation and Diagnosis/<br>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<br>Operating | 2<br>After<br>Consolidation* |    |
|----|-------------------------------------------------------------------|----------------|------------------------------|----|
|    | <b>A. Current Assets</b>                                          |                |                              |    |
| 1  | Cash on Hand and in Banks                                         | \$             | \$                           | 1  |
| 2  | Cash-Patient Deposits                                             |                |                              | 2  |
| 3  | Accounts & Short-Term Notes Receivable-Patients (less allowance ) | 51,320         | 51,320                       | 3  |
| 4  | Supply Inventory (priced at )                                     |                |                              | 4  |
| 5  | Short-Term Investments                                            |                |                              | 5  |
| 6  | Prepaid Insurance                                                 |                |                              | 6  |
| 7  | Other Prepaid Expenses                                            | 12,447         | 12,447                       | 7  |
| 8  | Accounts Receivable (owners or related parties)                   |                |                              | 8  |
| 9  | Other(specify): <u>Interdivision Receivable</u>                   | 2,091,988      | 2,091,988                    | 9  |
| 10 | <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>               | \$ 2,155,755   | \$ 2,155,755                 | 10 |
|    | <b>B. Long-Term Assets</b>                                        |                |                              |    |
| 11 | Long-Term Notes Receivable                                        |                |                              | 11 |
| 12 | Long-Term Investments                                             |                |                              | 12 |
| 13 | Land                                                              | 10,000         | 22,692                       | 13 |
| 14 | Buildings, at Historical Cost                                     | 502,427        | 489,735                      | 14 |
| 15 | Leasehold Improvements, at Historical Cost                        |                |                              | 15 |
| 16 | Equipment, at Historical Cost                                     | 114,771        | 114,771                      | 16 |
| 17 | Accumulated Depreciation (book methods)                           | (541,147)      | (529,949)                    | 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 | <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>           | \$ 86,051      | \$ 97,249                    | 24 |
| 25 | <b>TOTAL ASSETS (sum of lines 10 and 24)</b>                      | \$ 2,241,806   | \$ 2,253,004                 | 25 |

|    |                                                              | 1<br>Operating | 2<br>After<br>Consolidation* |    |
|----|--------------------------------------------------------------|----------------|------------------------------|----|
|    | <b>C. Current Liabilities</b>                                |                |                              |    |
| 26 | Accounts Payable                                             | \$ 1,669       | \$ 1,669                     | 26 |
| 27 | Officer's Accounts Payable                                   |                |                              | 27 |
| 28 | Accounts Payable-Patient Deposits                            |                |                              | 28 |
| 29 | Short-Term Notes Payable                                     |                |                              | 29 |
| 30 | Accrued Salaries Payable                                     | 9,449          | 9,449                        | 30 |
| 31 | Accrued Taxes Payable (excluding real estate taxes)          | 349            | 349                          | 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 |
|    | <b>Other Current Liabilities(specify):</b>                   |                |                              |    |
| 36 |                                                              |                |                              | 36 |
| 37 |                                                              |                |                              | 37 |
| 38 | <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>   | \$ 11,467      | \$ 11,467                    | 38 |
|    | <b>D. Long-Term Liabilities</b>                              |                |                              |    |
| 39 | Long-Term Notes Payable                                      |                |                              | 39 |
| 40 | Mortgage Payable                                             |                |                              | 40 |
| 41 | Bonds Payable                                                |                |                              | 41 |
| 42 | Deferred Compensation                                        |                |                              | 42 |
|    | <b>Other Long-Term Liabilities(specify):</b>                 |                |                              |    |
| 43 |                                                              |                |                              | 43 |
| 44 |                                                              |                |                              | 44 |
| 45 | <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b> | \$             | \$                           | 45 |
| 46 | <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>            | \$ 11,467      | \$ 11,467                    | 46 |
| 47 | <b>TOTAL EQUITY(page 18, line 24)</b>                        | \$ 2,230,339   | \$ 2,241,537                 | 47 |
| 48 | <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b> | \$ 2,241,806   | \$ 2,253,004                 | 48 |

XVI. STATEMENT OF CHANGES IN EQUITY

|    |                                                              |              |      |
|----|--------------------------------------------------------------|--------------|------|
|    |                                                              | 1<br>Total   |      |
| 1  | Balance at Beginning of Year, as Previously Reported         | \$ 2,129,327 | 1    |
| 2  | Restatements (describe):                                     |              | 2    |
| 3  |                                                              |              | 3    |
| 4  |                                                              |              | 4    |
| 5  |                                                              |              | 5    |
| 6  | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ 2,129,327 | 6    |
|    | A. Additions (deductions):                                   |              |      |
| 7  | NET Income (Loss) (from page 19, line 43)                    | 101,012      | 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)             | \$ 101,012   | 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)            | \$ 2,230,339 | 24 * |

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Carthage Terrace

# 0035543

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     |     |
|-----|-----------------------------------------------------------|------------|-----|
|     | <b>A. Inpatient Care</b>                                  |            |     |
| 1   | Gross Revenue -- All Levels of Care                       | \$ 633,267 | 1   |
| 2   | Discounts and Allowances for all Levels                   |            | 2   |
| 3   | <b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>      | \$ 633,267 | 3   |
|     | <b>B. Ancillary Revenue</b>                               |            |     |
| 4   | Day Care                                                  |            | 4   |
| 5   | Other Care for Outpatients                                |            | 5   |
| 6   | Therapy                                                   |            | 6   |
| 7   | Oxygen                                                    |            | 7   |
| 8   | <b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>        | \$         | 8   |
|     | <b>C. Other Operating Revenue</b>                         |            |     |
| 9   | Payments for Education                                    |            | 9   |
| 10  | Other Government Grants                                   |            | 10  |
| 11  | CNA Training Reimbursements                               | 14,722     | 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  | <b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b> | \$ 14,722  | 23  |
|     | <b>D. Non-Operating Revenue</b>                           |            |     |
| 24  | Contributions                                             |            | 24  |
| 25  | Interest and Other Investment Income***                   | 418        | 25  |
| 26  | <b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>   | \$ 418     | 26  |
|     | <b>E. Other Revenue (specify):****</b>                    |            |     |
| 27  | <b>Settlement Income (Insurance, Legal, Etc.)</b>         |            | 27  |
| 28  |                                                           |            | 28  |
| 28a |                                                           |            | 28a |
| 29  | <b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>      | \$         | 29  |
| 30  | <b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>   | \$ 648,407 | 30  |

2

|    | II. Expenses                                                   | Amount     |    |
|----|----------------------------------------------------------------|------------|----|
|    | <b>A. Operating Expenses</b>                                   |            |    |
| 31 | General Services                                               | 157,469    | 31 |
| 32 | Health Care                                                    | 184,589    | 32 |
| 33 | General Administration                                         | 147,327    | 33 |
|    | <b>B. Capital Expense</b>                                      |            |    |
| 34 | Ownership                                                      | 19,996     | 34 |
|    | <b>C. Ancillary Expense</b>                                    |            |    |
| 35 | Special Cost Centers                                           | 450        | 35 |
| 36 | Provider Participation Fee                                     | 37,564     | 36 |
|    | <b>D. Other Expenses (specify):</b>                            |            |    |
| 37 |                                                                |            | 37 |
| 38 |                                                                |            | 38 |
| 39 |                                                                |            | 39 |
| 40 | <b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>               | \$ 547,395 | 40 |
| 41 | <b>Income before Income Taxes (line 30 minus line 40)**</b>    | 101,012    | 41 |
| 42 | <b>Income Taxes</b>                                            |            | 42 |
| 43 | <b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b> | \$ 101,012 | 43 |

|    | III. Net Inpatient Revenue detailed by Payer Source                   |            |    |
|----|-----------------------------------------------------------------------|------------|----|
| 44 | Medicaid - Net Inpatient Revenue                                      | \$ 633,267 | 44 |
| 45 | Private Pay - Net Inpatient Revenue                                   |            | 45 |
| 46 | Medicare - Net Inpatient Revenue                                      |            | 46 |
| 47 | Other-(specify)                                                       |            | 47 |
| 48 | Other-(specify)                                                       |            | 48 |
| 49 | <b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b> | \$ 633,267 | 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.

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.<br>Actually<br>Worked | # of Hrs.<br>Paid and<br>Accrued | Reporting Period<br>Total Salaries,<br>Wages | Average<br>Hourly<br>Wage |    |
| 1  | Director of Nursing           |                                 |                                  | \$                                           | \$                        | 1  |
| 2  | Assistant Director of Nursing |                                 |                                  |                                              |                           | 2  |
| 3  | Registered Nurses             |                                 |                                  |                                              |                           | 3  |
| 4  | Licensed Practical Nurses     |                                 |                                  |                                              |                           | 4  |
| 5  | CNAs & Orderlies              | 12,020                          | 12,665                           | 132,815                                      | 10.49                     | 5  |
| 6  | CNA Trainees                  |                                 |                                  |                                              |                           | 6  |
| 7  | Licensed Therapist            |                                 |                                  |                                              |                           | 7  |
| 8  | Rehab/Therapy Aides           |                                 |                                  |                                              |                           | 8  |
| 9  | Activity Director             |                                 |                                  |                                              |                           | 9  |
| 10 | Activity Assistants           |                                 |                                  |                                              |                           | 10 |
| 11 | Social Service Workers        |                                 |                                  |                                              |                           | 11 |
| 12 | Dietician                     |                                 |                                  |                                              |                           | 12 |
| 13 | Food Service Supervisor       |                                 |                                  |                                              |                           | 13 |
| 14 | Head Cook                     |                                 |                                  |                                              |                           | 14 |
| 15 | Cook Helpers/Assistants       | 2,872                           | 3,023                            | 38,281                                       | 12.66                     | 15 |
| 16 | Dishwashers                   |                                 |                                  |                                              |                           | 16 |
| 17 | Maintenance Workers           | 929                             | 1,057                            | 11,662                                       | 11.03                     | 17 |
| 18 | Housekeepers                  | 1,853                           | 1,913                            | 21,248                                       | 11.11                     | 18 |
| 19 | Laundry                       |                                 |                                  |                                              |                           | 19 |
| 20 | Administrator                 | 463                             | 496                              | 14,272                                       | 28.77                     | 20 |
| 21 | Assistant Administrator       |                                 |                                  |                                              |                           | 21 |
| 22 | Other Administrative          |                                 |                                  |                                              |                           | 22 |
| 23 | Office Manager                |                                 |                                  |                                              |                           | 23 |
| 24 | Clerical                      | 297                             | 307                              | 3,870                                        | 12.61                     | 24 |
| 25 | Vocational Instruction        |                                 |                                  |                                              |                           | 25 |
| 26 | Academic Instruction          |                                 |                                  |                                              |                           | 26 |
| 27 | Medical Director              |                                 |                                  |                                              |                           | 27 |
| 28 | Qualified MR Prof. (QMRP)     | 787                             | 825                              | 16,756                                       | 20.31                     | 28 |
| 29 | Resident Services Coordinator |                                 |                                  |                                              |                           | 29 |
| 30 | Habilitation Aides (DD Homes) |                                 |                                  |                                              |                           | 30 |
| 31 | Medical Records               |                                 |                                  |                                              |                           | 31 |
| 32 | Other Health Care(specify)    |                                 |                                  |                                              |                           | 32 |
| 33 | Other(specify)                |                                 |                                  |                                              |                           | 33 |
| 34 | TOTAL (lines 1 - 33)          | 19,221                          | 20,286                           | \$ 238,904 *                                 | \$ 11.78                  | 34 |

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

\*\* See instructions.

B. CONSULTANT SERVICES

|    |                                 | 1                                      | 2                                                   | 3                                           |    |
|----|---------------------------------|----------------------------------------|-----------------------------------------------------|---------------------------------------------|----|
|    |                                 | Number<br>of Hrs.<br>Paid &<br>Accrued | Total Consultant<br>Cost for<br>Reporting<br>Period | Schedule V<br>Line &<br>Column<br>Reference |    |
| 35 | Dietary Consultant              | Monthly                                | \$ 1,020                                            | L1, C3                                      | 35 |
| 36 | Medical Director                | Monthly                                | 2,000                                               | L9, C3                                      | 36 |
| 37 | Medical Records Consultant      |                                        |                                                     |                                             | 37 |
| 38 | Nurse Consultant                | Monthly                                | 4,499                                               | L10, C3                                     | 38 |
| 39 | Pharmacist Consultant           | Monthly                                | 933                                                 | L10, C3                                     | 39 |
| 40 | Physical Therapy Consultant     |                                        |                                                     |                                             | 40 |
| 41 | Occupational Therapy Consultant |                                        |                                                     |                                             | 41 |
| 42 | Respiratory Therapy Consultant  |                                        |                                                     |                                             | 42 |
| 43 | Speech Therapy Consultant       |                                        |                                                     |                                             | 43 |
| 44 | Activity Consultant             |                                        |                                                     |                                             | 44 |
| 45 | Social Service Consultant       |                                        |                                                     |                                             | 45 |
| 46 | Other(specify) Dental           | Monthly                                | 3,636                                               | L10, C3                                     | 46 |
| 47 | Psychological Consultant        | Monthly                                | 2,650                                               | L10, C3                                     | 47 |
| 48 |                                 |                                        |                                                     |                                             | 48 |
| 49 | TOTAL (lines 35 - 48)           |                                        | \$ 14,738                                           |                                             | 49 |

C. CONTRACT NURSES

|    |                                  | 1                                      | 2                          | 3                                           |    |
|----|----------------------------------|----------------------------------------|----------------------------|---------------------------------------------|----|
|    |                                  | Number<br>of Hrs.<br>Paid &<br>Accrued | Total<br>Contract<br>Wages | Schedule V<br>Line &<br>Column<br>Reference |    |
| 50 | Registered Nurses                | N/A                                    | \$                         |                                             | 50 |
| 51 | Licensed Practical Nurses        |                                        |                            |                                             | 51 |
| 52 | Certified Nurse Assistants/Aides |                                        |                            |                                             | 52 |
| 53 | TOTAL (lines 50 - 52)            |                                        | \$                         |                                             | 53 |

SEE ACCOUNTANTS' PREPARATION REPORT

|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|---------------------------------------------------------|--|-------------------------|-----------|----------------------------------------|--------------------------------------------|-----------|-----------|---------------------------------------------|-----------------------|----------|--|---------|--|---------|--|---------|--|
| Facility Name & ID Number                               |  | Carthage Terrace        |           | STATE OF ILLINOIS                      |                                            | # 0035543 |           | Report Period Beginning:                    |                       | 10/1/15  |  | Page 21 |  | Ending: |  | 9/30/16 |  |
| XIX. SUPPORT SCHEDULES                                  |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
| A. Administrative Salaries                              |  |                         |           | D. Employee Benefits and Payroll Taxes |                                            |           |           | F. Dues, Fees, Subscriptions and Promotions |                       |          |  |         |  |         |  |         |  |
| Name                                                    |  | Function                | Ownership | Amount                                 | Description                                |           | Amount    | Description                                 |                       | Amount   |  |         |  |         |  |         |  |
| Annette Whitlock                                        |  | Administrator           | None      | \$ 14,272                              | Workers' Compensation Insurance            |           | \$ 6,263  | IDPH License Fee                            |                       | \$       |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | Unemployment Compensation Insurance        |           |           | Advertising: Employee Recruitment           |                       | 3,970    |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | FICA Taxes                                 |           | 16,650    | Health Care Worker Background Check         |                       | 520      |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | Employee Health Insurance                  |           | 16,749    | (Indicate # of checks performed 21 )        |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | Employee Meals                             |           | 1,274     | Patient Background Checks                   |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | Illinois Municipal Retirement Fund (IMRF)* |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | 401k                                       |           | 346       | Subscriptions                               |                       | 604      |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | Other Employee Benefits                    |           | 650       | IHCA Dues                                   |                       | 912      |  |         |  |         |  |         |  |
| TOTAL (agree to Schedule V, line 17, col. 1)            |  |                         |           |                                        |                                            |           |           | Other Licenses & Fees                       |                       | 10       |  |         |  |         |  |         |  |
| (List each licensed administrator separately.)          |  |                         |           | \$ 14,272                              |                                            |           |           | Indirect costs                              |                       | 49       |  |         |  |         |  |         |  |
| B. Administrative - Other                               |  |                         |           |                                        | Indirect costs                             |           | 4         | Less: Public Relations Expense              |                       | ( )      |  |         |  |         |  |         |  |
| Description                                             |  |                         |           | Amount                                 |                                            |           |           | Non-allowable advertising                   |                       | ( )      |  |         |  |         |  |         |  |
| N/A                                                     |  |                         |           | \$                                     |                                            |           |           | Yellow page advertising                     |                       | ( )      |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           | TOTAL (agree to Sch. V,                     |                       | \$ 6,065 |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | TOTAL (agree to Schedule V,                |           | \$ 41,936 | line 20, col. 8)                            |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        | line 22, col.8)                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
| TOTAL (agree to Schedule V, line 17, col. 3)            |  |                         |           | \$                                     | E. Schedule of Non-Cash Compensation Paid  |           |           | G. Schedule of Travel and Seminar**         |                       |          |  |         |  |         |  |         |  |
| (Attach a copy of any management service agreement)     |  |                         |           |                                        | to Owners or Employees                     |           |           | Description                                 |                       | Amount   |  |         |  |         |  |         |  |
| C. Professional Services                                |  |                         |           |                                        | Description                                |           | Line #    | Amount                                      |                       |          |  |         |  |         |  |         |  |
| Vendor/Payee                                            |  | Type                    |           | Amount                                 |                                            |           |           |                                             | Out-of-State Travel   |          |  |         |  |         |  |         |  |
| RFMS, Inc.                                              |  | Administrative Services |           | \$ 33,990                              | N/A                                        |           |           |                                             | \$                    |          |  |         |  |         |  |         |  |
| LTC Support Services, LLC                               |  | Support Services        |           | 25,560                                 |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
| RSM US LLP                                              |  | Accounting Services     |           | 1,853                                  |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
| Templin Healthcare Accounting                           |  | Accounting Services     |           | 1,002                                  |                                            |           |           |                                             | In-State Travel       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             | Seminar Expense       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             | 459                   |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             |                       |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             | Entertainment Expense |          |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           |                                             | ( )                   |          |  |         |  |         |  |         |  |
| TOTAL (agree to Schedule V, line 19, column 3)          |  |                         |           |                                        | TOTAL                                      |           | \$        | (agree to Sch. V,                           |                       |          |  |         |  |         |  |         |  |
| (For legal fee disclosure, see page 39 of instructions) |  |                         |           | \$ 62,405                              |                                            |           |           | TOTAL                                       |                       | \$ 459   |  |         |  |         |  |         |  |
|                                                         |  |                         |           |                                        |                                            |           |           | line 24, col. 8)                            |                       |          |  |         |  |         |  |         |  |

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

\*\*See instructions.

|                           |                                                                                                                                                                                                      |                  |  |                                |   |         |                          |         |         |         |         |
|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--|--------------------------------|---|---------|--------------------------|---------|---------|---------|---------|
| Facility Name & ID Number |                                                                                                                                                                                                      | Carthage Terrace |  | STATE OF ILLINOIS              | # | 0035543 | Report Period Beginning: | 10/1/15 | Ending: | 9/30/16 | Page 22 |
| XX. GENERAL INFORMATION:  |                                                                                                                                                                                                      |                  |  |                                |   |         |                          |         |         |         |         |
| (1)                       | Are nursing employees (RN,LPN,NA) represented by a union?                                                                                                                                            |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
| (2)                       | Are there any dues to nursing home associations included on the cost report?                                                                                                                         |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
|                           | If YES, give association name and amount.                                                                                                                                                            |                  |  | <u>912 IHCA</u>                |   |         |                          |         |         |         |         |
| (3)                       | Did the nursing home make political contributions or payments to a political action organization?                                                                                                    |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | If YES, have these costs been properly adjusted out of the cost report?                                                                                                                              |                  |  | <u>N/A</u>                     |   |         |                          |         |         |         |         |
| (4)                       | Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?                                                                                         |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | If YES, what is the capacity?                                                                                                                                                                        |                  |  | <u>N/A</u>                     |   |         |                          |         |         |         |         |
| (5)                       | Have you properly capitalized all major repairs and equipment purchases?                                                                                                                             |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
|                           | What was the average life used for new equipment added during this period?                                                                                                                           |                  |  | <u>5 yrs</u>                   |   |         |                          |         |         |         |         |
| (6)                       | Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.                                                                           |                  |  | \$ <u>3,990</u> Line <u>10</u> |   |         |                          |         |         |         |         |
| (7)                       | Have all costs reported on this form been determined using accounting procedures consistent with prior reports?                                                                                      |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
|                           | If NO, attach a complete explanation.                                                                                                                                                                |                  |  |                                |   |         |                          |         |         |         |         |
| (8)                       | Are you presently operating under a sale and leaseback arrangement?                                                                                                                                  |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | If YES, give effective date of lease.                                                                                                                                                                |                  |  | <u>N/A</u>                     |   |         |                          |         |         |         |         |
| (9)                       | Are you presently operating under a sublease agreement?                                                                                                                                              |                  |  | YES <u>X</u> NO                |   |         |                          |         |         |         |         |
| (10)                      | Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?                                                                                           |                  |  | YES NO <u>X</u>                |   |         |                          |         |         |         |         |
|                           | 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.                                                                            |                  |  | \$ <u>37,564</u>               |   |         |                          |         |         |         |         |
|                           | 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?                                                                                 |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | 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? |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
| (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?                                                            |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | 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.                                                                                                    |                  |  | \$ <u>1,274</u>                |   |         |                          |         |         |         |         |
|                           | Has any meal income been offset against related costs?                                                                                                                                               |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | Indicate the amount.                                                                                                                                                                                 |                  |  | \$ <u>N/A</u>                  |   |         |                          |         |         |         |         |
| (16)                      | Travel and Transportation                                                                                                                                                                            |                  |  |                                |   |         |                          |         |         |         |         |
|                           | a. Are there costs included for out-of-state travel?                                                                                                                                                 |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | If YES, attach a complete explanation.                                                                                                                                                               |                  |  |                                |   |         |                          |         |         |         |         |
|                           | b. Do you have a separate contract with the Department to provide medical transportation for residents?                                                                                              |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | If YES, please indicate the amount of income earned from such a program during this reporting period.                                                                                                |                  |  | \$ <u>N/A</u>                  |   |         |                          |         |         |         |         |
|                           | c. What percent of all travel expense relates to transportation of nurses and patients?                                                                                                              |                  |  | <u>None</u>                    |   |         |                          |         |         |         |         |
|                           | d. Have vehicle usage logs been maintained?                                                                                                                                                          |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
|                           | e. Are all vehicles stored at the nursing home during the night and all other times when not in use?                                                                                                 |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
|                           | f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?                                                                                                   |                  |  | <u>N/A</u>                     |   |         |                          |         |         |         |         |
|                           | g. Does the facility transport residents to and from day training?                                                                                                                                   |                  |  | <u>No</u>                      |   |         |                          |         |         |         |         |
|                           | Indicate the amount of income earned from providing such transportation during this reporting period.                                                                                                |                  |  | \$ <u>N/A</u>                  |   |         |                          |         |         |         |         |
| (17)                      | Has an audit been performed by an independent certified public accounting firm?                                                                                                                      |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
|                           | Firm Name:                                                                                                                                                                                           |                  |  | <u>RSM US LLP</u>              |   |         |                          |         |         |         |         |
| (18)                      | Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?                                                                                               |                  |  | <u>Yes</u>                     |   |         |                          |         |         |         |         |
| (19)                      | Has a schedule for the legal fees reported on the cost report been provided by the facility?                                                                                                         |                  |  | <u>N/A</u>                     |   |         |                          |         |         |         |         |
|                           | See page 39 of the instructions for details.                                                                                                                                                         |                  |  |                                |   |         |                          |         |         |         |         |
|                           | Attach invoices and a summary of services for all architect and appraisal fees                                                                                                                       |                  |  |                                |   |         |                          |         |         |         |         |

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