

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0035410</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Lincoln Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/15</u> to <u>9/30/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>2324 N Kickapoo St</u> <u>Lincoln</u> <u>62656</u>																																																			
Number City Zip Code																																																			
County: <u>Logan</u>																																																			
Telephone Number: <u>(217) 732-4422</u> Fax # <u>(217) 732-6547</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>06/08/89</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY,NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 (c) 3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☒	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 (c) 3</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust					☐	Other _____				
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		☐	Limited Liability Co.	_____																																															
		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>Ron Wilson</u>																																																			
Telephone Number: <u>(309) 343-1550</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) <u>Pat Devine</u></td></tr><tr><td>(Title) <u>Executive Director</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Larry Templin</u> <u>Partner</u></td></tr><tr><td rowspan="3"></td><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Pat Devine</u>	(Title) <u>Executive Director</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>		(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																			
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace

0035410 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	5,638			5,638
14	TOTALS	5,638			5,638

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.28%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?
98 (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 06/08/89

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/24/90 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

ACCRUAL ☒ MODIFIED 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.

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/15 Ending: 9/30/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	37,845	5,353	945	44,143		44,143		44,143			1
2	Food Purchase		50,427		50,427		50,427		50,427			2
3	Housekeeping	20,977	6,195		27,172		27,172		27,172			3
4	Laundry		2,681		2,681		2,681		2,681			4
5	Heat and Other Utilities			17,651	17,651		17,651		17,651			5
6	Maintenance	11,685	4,174	8,463	24,322		24,322	148	24,470			6
7	Other (specify):*											7
8	TOTAL General Services	70,507	68,830	27,059	166,396		166,396	148	166,544			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	167,146	9,040	9,415	185,601		185,601		185,601			10
10a	Therapy											10a
11	Activities		450	769	1,219		1,219		1,219			11
12	Social Services											12
13	CNA Training	10,534			10,534		10,534		10,534			13
14	Program Transportation			7,245	7,245		7,245		7,245			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	177,680	9,490	21,929	209,099		209,099		209,099			16
	C. General Administration											
17	Administrative	14,356			14,356		14,356		14,356			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			5,224	5,224		5,224	49	5,273			20
21	Clerical & General Office Expenses	25,872	4,439	4,459	34,770		34,770	2	34,772			21
22	Employee Benefits & Payroll Taxes			55,281	55,281		55,281	4	55,285			22
23	Inservice Training & Education			4,396	4,396		4,396	3	4,399			23
24	Travel and Seminar			134	134		134		134			24
25	Other Admin. Staff Transportation			2,003	2,003		2,003		2,003			25
26	Insurance-Prop.Liab.Malpractice			5,736	5,736		5,736	842	6,578			26
27	Other (specify):*											27
28	TOTAL General Administration	40,228	4,439	139,638	184,305		184,305	3,837	188,142			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	288,415	82,759	188,626	559,800		559,800	3,985	563,785			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			22,556	22,556		22,556	(429)	22,127			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			22,556	22,556		22,556	(429)	22,127			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			37,933	37,933		37,933		37,933			42
43	Other (specify):* Disallowed Costs			2,030	2,030		2,030	(2,030)				43
44	TOTAL Special Cost Centers			39,963	39,963		39,963	(2,030)	37,933			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	288,415	82,759	251,145	622,319		622,319	1,526	623,845			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(429)	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	(223)	43		24
25	Fund Raising, Advertising and Promotional	(1,807)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,459)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,985		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,985		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 1,526		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		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
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21				21
22				22
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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 Lincoln Terrace # 0035410 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 Lincoln Terrace # 0035410 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	(429)	0	0	0	0	0	0	0	0	0	0	(429)	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	(429)	0	0	0	0	0	0	0	0	0	0	(429)	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):*	(2,030)	0	0	0	0	0	0	0	0	0	0	(2,030)	43
44	TOTAL Special Cost Centers	(2,030)	0	0	0	0	0	0	0	0	0	0	(2,030)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,459)	3,985	0	0	0	0	0	0	0	0	0	1,526	45

VII. RELATED PARTIES

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

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

Lincoln Terrace# 0035410

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Lincoln Terrace# 0035410

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 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Tanner Place</u>	<u>Paris</u>				1
2	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Taylor House</u>	<u>Springfield</u>				2
3	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Thelma Terrace</u>	<u>Wood River</u>				3
4	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Trulson House</u>	<u>Galesburg</u>				4
5	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Vahle Terrace</u>	<u>Jerseyville</u>				5
6	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Walsh Terrace</u>	<u>Galesburg</u>				6
7	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Wetherell Place</u>	<u>Effingham</u>				7
8	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Woodriver Group Homes:</u>					8
9	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Aberdeen Terrace</u>	<u>Alton</u>				9
10	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Linton Terrace</u>	<u>Wood River</u>				10
11	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Madison Terrace</u>	<u>Wood River</u>				11
12	<u>Community Living Options, Inc.</u>	<u>100%</u>	<u>Pershing Terrace</u>	<u>Wood River</u>				12
13	<u>Community Living Options, Inc.</u>	<u>100%</u>			<u>Audrey Court-CILA</u>	<u>Clinton</u>	<u>CILA</u>	13
14	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Parkway Manor</u>	<u>Marion</u>				14
15	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Parkway Estates</u>	<u>Marion</u>	<u>Retirement living ce</u>	15
16	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Maryville Manor</u>	<u>Maryville</u>				16
17	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Shelbyville Manor</u>	<u>Shelbyville</u>				17
18	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Leroy Manor</u>	<u>Leroy</u>				18
19	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Liberty Estates of Carl</u>	<u>Carbondale</u>	<u>Retirement living ce</u>	19
20	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Care Center of Abingdon</u>	<u>Abingdon</u>				20
21	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Seminary Manor</u>	<u>Galesburg</u>				21
22	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Seminary Estates</u>	<u>Galesburg</u>	<u>Retirement living ce</u>	22
23	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Hawthorne Inn of Gale</u>	<u>Galesburg</u>	<u>Assisted Living Faci</u>	23
24	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Centralia Manor</u>	<u>Centralia</u>				24
25	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Centralia Estates</u>	<u>Centralia Estates</u>	<u>Retirement living ce</u>	25
26	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Pittsfield Manor</u>	<u>Pittsfield</u>				26
27	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Pekin Manor</u>	<u>Pekin</u>				27
28	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Pekin Estates</u>	<u>Pekin</u>	<u>Retirement living ce</u>	28
29	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>Jerseyville Manor</u>	<u>Jerseyville</u>				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 OWNERS		2 RELATED NURSING HOMES		3 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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

Ending: 9/30/16

(309) 343-2857

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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2015		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	N/A	8	
		2012	N/A	9	
		2013	N/A	10	
		2014	N/A	11	
		2015	N/A	12	
The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Lincoln Terrace COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0035410

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

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? X(a) Own the Facility(b) Rent from a Related Organization.(c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

If so, please complete the following:

1. Total Amount Incurred:2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	52,300	1990	\$ 22,692	1
2					2
3	TOTALS	52,300		\$ 22,692	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1990	1989	\$ 412,308	\$ 14,173	30	\$ 13,744	\$ (429)	\$ 363,091
5										
6										
7										
8										
	Improvement Type**									
9	Garage, Parking Lot, Sidewalks and Landscaping			1989	30,000		15			30,000
10	Carpeting			1997	6,716		7			6,716
11	2 A/C Units, Shower			2004	14,714		7-10yrs			14,714
12	Shower, Carpet/Vinyl, Water Heaters			2005	8,040	5	7-10yrs	5		8,040
13	Kitchen Cabinets/Bathroom Cabinets/Sinks/Faucets/Mirrors			2007	9,720	648	15	648		6,012
14	Cabinets			2009	6,844	456	15	456		3,460
15	Roof Repair			2009	16,304	1,631	10	1,631		11,958
16	Bathroom Remodel-Vanity/Cabinets/Toilet/Floor/Drains			2011	32,738	2,728	12	2,728		15,005
17	Handrails, Corner Guards, Wall Guards			2011	3,964	793	5	793		3,898
18	Bathroom 1 - New Toilet/Cement Board/Tile/Cabinets/Paint/Fixtures			2016	25,308	405	12	405		405
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 & ID Number Lincoln Terrace

0035410

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 566,656	\$ 20,839		\$ 20,410	\$ (429)	\$ 463,299	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$54,481	\$1,343	\$1,343	\$	3-15 yrs	\$47,875	71
72	Current Year Purchases	2,490	374	374		5 yrs	374	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$56,971	\$1,717	\$1,717	\$		\$48,249	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2001 Ford E350 Van	2002	\$18,301	\$		\$	4	\$18,301	76
77										77
78										78
79										79
80	TOTALS			\$18,301	\$	\$	\$		\$18,301	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)	\$664,620	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$22,556	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$22,127	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(429)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$529,849	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	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.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES☐ NO
- Terms: N/A
- *

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

15. Is Movable equipment rental included in building rental?
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 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense 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)		10,534		10,534
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 10,534	\$	\$ 10,534
10	SUM OF line 9, col. 1 and 2 (e)	\$ 10,534			

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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
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			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	1,263,872	1,263,872	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,315,192	\$ 1,315,192	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	22,692	13
14	Buildings, at Historical Cost	579,348	566,656	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	75,272	75,272	16
17	Accumulated Depreciation (book methods)	(541,020)	(529,849)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 123,600	\$ 134,771	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,438,792	\$ 1,449,963	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,832	\$ 3,832	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,970	8,970	30
31	Accrued Taxes Payable (excluding real estate taxes)	313	313	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,115	\$ 13,115	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,115	\$ 13,115	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,425,677	\$ 1,436,848	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,438,792	\$ 1,449,963	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,396,095	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,396,094	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,583	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)	\$ 29,583	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,425,677	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace

0035410

Report Period Beginning: 10/1/15

Ending:

9/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 640,981	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 640,981	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	10,534	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,534	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***	337	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 387	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 651,902	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	166,396	31
32	Health Care	209,099	32
33	General Administration	184,305	33
	B. Capital Expense		
34	Ownership	22,556	34
	C. Ancillary Expense		
35	Special Cost Centers	2,030	35
36	Provider Participation Fee	37,933	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 622,319	40
41	Income before Income Taxes (line 30 minus line 40)**	29,583	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 29,583	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 640,981	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 640,981	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. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	656	720	16,588	23.04	4
5	CNAs & Orderlies	12,284	13,139	129,002	9.82	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	2,868	3,026	37,845	12.51	15
16	Dishwashers					16
17	Maintenance Workers	966	1,027	11,685	11.38	17
18	Housekeepers	1,913	2,097	20,977	10.00	18
19	Laundry					19
20	Administrator	499	540	14,356	26.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,074	2,228	25,872	11.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,606	1,728	32,090	18.57	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)	22,866	24,505	\$ 288,415 *	\$ 11.77	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 945	L1, C3	35
36	Medical Director	Monthly	4,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,147	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	6,288	L10, C3	46
47	Psychological Consultant	Monthly	1,980	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,860		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column 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

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

** See instructions.

Facility Name & ID Number		Lincoln Terrace	STATE OF ILLINOIS		#	0035410	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			
Adam Tabor		Administrator	None	\$ 14,356	Workers' Compensation Insurance		\$ 7,361	IDPH License Fee		\$			
					Unemployment Compensation Insurance		199	Advertising: Employee Recruitment		1,360			
					FICA Taxes		23,750	Health Care Worker Background Check		1,050			
					Employee Health Insurance		17,036	(Indicate # of checks performed 105)					
					Employee Meals		1,437	Patient Background Checks					
					Illinois Municipal Retirement Fund (IMRF)*								
					401k		3,838	Subscriptions		1,840			
					Other Employee Benefits		1,660	IHCA Dues		912			
								Other Licenses & Fees		62			
								Indirect costs		49			
								Less: Public Relations Expense		()			
								Non-allowable advertising		()			
								Yellow page advertising		()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 14,356						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,273	
B. Administrative - Other													
Description				Amount									
N/A				\$									
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$									
C. Professional Services													
Vendor/Payee		Type	Amount		Description		Line #	Amount	Description		Amount		
RFMS, Inc.		Administrative Services	\$ 33,990		N/A			\$	Out-of-State Travel		\$		
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		134		
									Entertainment Expense		()		
									(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 62,405	TOTAL			\$	TOTAL		\$ 134		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number		Lincoln Terrace		STATE OF ILLINOIS	#	0035410	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>1,711</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>37,933</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>1,437</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										

SEE ACCOUNTANTS' PREPARATION REPORT