

		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>0012765</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Pinecrest Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2015</u> to <u>06/30/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>414 S Wesley Avenue</u> <u>Mount Morris</u> <u>61054</u>																									
Number City Zip Code																									
County: <u>Ogle</u>																									
Telephone Number: <u>(815) 734-4103</u> Fax # <u>(815) 734-7131</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>												
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	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																								
Date of Initial License for Current Owners: <u>6/27/1963</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>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:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____																									

Facility Name & ID Number Pinecrest Manor

0012765 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

III. STATISTICAL DATA

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

	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	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,888</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>125</u>	TOTALS	<u>125</u>	<u>45,750</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,386</u>	<u>3,932</u>	<u>3,743</u>	<u>16,061</u>	8
9	SNF/PED					9
10	ICF	<u>11,277</u>	<u>12,343</u>		<u>23,620</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,663</u>	<u>16,275</u>	<u>3,743</u>	<u>39,681</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.73%

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

None (Do not include bed-hold days in Section B.)

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Note : 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 6/27/63

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 57 and days of care provided 2,739

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Pinecrest Manor # 0012765 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	479,352	30,509	24,602	534,463		534,463	(70,320)	464,143			1
2	Food Purchase		535,966		535,966		535,966	(111,484)	424,482			2
3	Housekeeping	289,076	27,247	37,925	354,248		354,248	(86,625)	267,623			3
4	Laundry	162,393	17,805		180,198		180,198		180,198			4
5	Heat and Other Utilities			317,271	317,271		317,271		317,271			5
6	Maintenance	284,213	13,611	82,828	380,652		380,652	(90,786)	289,866			6
7	Other (specify):*											7
8	TOTAL General Services	1,215,034	625,138	462,626	2,302,798		2,302,798	(359,215)	1,943,583			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	3,047,476	122,671	53,824	3,223,971		3,223,971		3,223,971			10
10a	Therapy											10a
11	Activities	135,130	5,329	2,605	143,064		143,064	(334)	142,730			11
12	Social Services	163,829	51	357	164,237		164,237		164,237			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,346,435	128,051	63,386	3,537,872		3,537,872	(334)	3,537,538			16
	C. General Administration											
17	Administrative	106,000			106,000		106,000		106,000			17
18	Directors Fees											18
19	Professional Services			193,578	193,578		193,578	(1,953)	191,625			19
20	Dues, Fees, Subscriptions & Promotions			11,887	11,887		11,887	(352)	11,535			20
21	Clerical & General Office Expenses	362,038	81,820	59,506	503,364		503,364	(30,555)	472,809			21
22	Employee Benefits & Payroll Taxes			1,060,169	1,060,169		1,060,169	(72,783)	987,386			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,437	17,437		17,437		17,437			24
25	Other Admin. Staff Transportation			6,215	6,215		6,215		6,215			25
26	Insurance-Prop.Liab.Malpractice			116,438	116,438		116,438		116,438			26
27	Other (specify):*											27
28	TOTAL General Administration	468,038	81,820	1,465,230	2,015,088		2,015,088	(105,643)	1,909,445			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,029,507	835,009	1,991,242	7,855,758		7,855,758	(465,192)	7,390,566			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			320,205	320,205		320,205	16,340	336,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			120,662	120,662		120,662	(1,064)	119,598			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,919	6,919		6,919		6,919			35
36	Other (specify):*											36
37	TOTAL Ownership			447,786	447,786		447,786	15,276	463,062			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,112	532,050	646,162		646,162		646,162			39
40	Barber and Beauty Shops			31,861	31,861		31,861		31,861			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			290,856	290,856		290,856		290,856			42
43	Other (specify):* Non-Allowable Cos	134,310	13,808	528,806	676,924		676,924	(676,924)				43
44	TOTAL Special Cost Centers	134,310	127,920	1,383,573	1,645,803		1,645,803	(676,924)	968,879			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,163,817	962,929	3,822,601	9,949,347		9,949,347	(1,126,840)	8,822,507			45

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

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	(27,450)	2		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	16,340	30		9
10	Interest and Other Investment Income	(1,064)	32		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	(1,953)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(478,370)	43		24
25	Fund Raising, Advertising and Promotional	(7,068)	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 See Page 5A	(123,275)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (622,840)		\$	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)	(504,000)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (504,000)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,126,840)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow association dues	\$ (125)	20	1
2	Offset miscellaneous Income	(617)	21	2
3	Disallow development salary	(55,204)	43	3
4	Disallow development consultant	(50)	43	4
5	Disallow development general exp	(3,662)	43	5
6	Disallow development events	(4,928)	43	6
7	Disallow development postage	(1,669)	43	7
8	Disallow development office supplies	(3,145)	43	8
9	Disallow development other supplies	(404)	43	9
10	Disallow cable tv expense	(26,565)	43	10
11	Disallow Medicare EKG - Part A	(8)	43	11
12	Disallow Medicare Lab - Part A	(3,877)	43	12
13	Disallow Medicare X-Ray - Part A	(6,313)	43	13
14	Disallow development conference/education	(443)	43	14
15	Disallow development travel expense	(257)	43	15
16	Disallow development service contracts	(1,345)	43	16
17	Disallow marketing/public relations cost	(3,656)	43	17
18	Disallow general expense	(854)	43	18
19	Disallow marketing salaries	(9,592)	43	19
20	Offset pet expense	(334)	11	20
21	Disallow Lobbying Expense	(227)	20	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	(123,275)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Brethren Home	100%			Pinecrest Village	Mt. Morris, IL	Retirement
						Community
				Pinecrest	Mt. Morris, IL	Fund Raising
				Foundation		Foundation
				Pinecrest Grove	Mt. Morris, IL	Independent
						Living

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	1	Dietary Salary	\$ 42,870	Pinecrest Village	**	\$	\$ (42,870)	1
2	V	2	Food	111,483	Pinecrest Village	**		(111,483)	2
3	V	3	Housekeeping Salary	86,625	Pinecrest Village	**		(86,625)	3
4	V	6	Plant Salary	77,486	Pinecrest Village	**		(77,486)	4
5	V	21	Clerical & General Office-Salary	29,938	Pinecrest Village	**		(29,938)	5
6	V	22	Employee benefits & payroll taxes	66,798	Pinecrest Village	**		(66,798)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V				** Pinecrest Manor, Pinecrest Village & Pinecrest Grove				12
13	V				share a common Board of Directors				13
14	Total			\$ 415,200			\$	\$ * (415,200)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$ 13,300	Pinecrest Grove	**	\$	\$ (13,300)	15
16	V	43	Marketing Wages	69,515	Pinecrest Grove	**		(69,515)	16
17	V	22	Employee Benefits	5,985	Pinecrest Grove	**		(5,985)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V				** Pinecrest Manor, Pinecrest Village & Pinecrest Grove				34
35	V				share a common Board of Directors				35
36	V								36
37	V								37
38	V								38
39	Total			\$ 88,800			\$ 0	\$ * (88,800)	39

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

Facility Name & ID Number Pinecrest Manor # 0012765 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3		See Listing of Board of Directors Attached									3
4											4
5		Note: No members of the Board provide services to the facility, nor do they have									5
6		financial interest in business that do business with, or provide services to the facility.									6
7											7
8		No member of the Board received any compensation from this or any other nursing									8
9		home.									9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pinecrest Manor # 0012765 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address _____
City / State / Zip Code _____
Phone Number ()
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3	N/A								3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	JP Morgan Chase		X	Bond Issue	Interest Only	6/17/00	\$ 5,200,000	\$ 3,830,036	6/27/27	LI +.0050	\$ 116,958	1
2	Midland States Bank		X	Mortgage	26202.05	8/1/13	274,860	100,669	10/30/2016	Variable	3,704	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$26,202.05		\$ 5,474,860	\$ 3,930,705			\$ 120,662	9
	B. Non-Facility Related*											
10												10
11												11
12							Interest Income Offset				(1,064)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,064)	14
15	TOTALS (line 9+line14)						\$ 5,474,860	\$ 3,930,705			\$ 119,598	15

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

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

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.							
1. Real Estate Tax accrual used on 2015 report.		\$	1					
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	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.	Alloc. Fr. Mgmt Co.							
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 _____ <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>8</td></tr><tr><td>9</td></tr><tr><td>10</td></tr><tr><td>11</td></tr><tr><td>12</td></tr></table> 2012 _____ 2013 _____ 2014 _____ 2015 _____	8	9	10	11	12		
8								
9								
10								
11								
12								
Facility is a not-for-profit and pays no real estate taxes.								

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

FACILITY NAME	<u>Pinecrest Manor</u>	COUNTY	<u>Ogle</u>
---------------	------------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT Kim Macklin

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,970

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).

Pinecrest Village-Retirement Community

Congregate living units-48 units-60,413 square feet

Independent living units-9 units-12,079 square feet

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: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1		Resident Care	443,048	1889	\$ 20,626	1	
2						2	
3		TOTALS	443,048		\$ 20,626	3	

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	125		1963	1963	\$ 1,248,321	\$	50	\$	\$	\$ 1,248,321	4
5			1964	1964	13,640		50			13,640	5
6			1965	1965	400		50	4	4	400	6
7			1963	1963	67,803		5-20			67,803	7
8			1987	1987	43,345		5-10			43,345	8
	Improvement Type**										
9	Building Improvements			1965	5,475		38			5,475	9
10	Building Improvements			1969	3,231	-	15-45			3,231	10
11	Building Improvements			1971	9,871	-	5-42			9,871	11
12	Building Improvements			1972	4,539	-	10			4,539	12
13	Building Improvements			1973	567	-	5			567	13
14	Building Improvements			1974	130,481	2,821	5-50	2821		111,457	14
15	Building Improvements			1975	17,918	-	10-15			17,918	15
16	Building Improvements			1976	22,483	-	5-38			22,483	16
17	Building Improvements			1977	12,308	-	10			12,308	17
18	Building Improvements			1978	1,354	-	5-10			1,354	18
19	Building Improvements			1979	10,885	-	7			10,885	19
20	Building Improvements			1980	6,121		5			6,121	20
21	Building Improvements			1981	8,640		10			8,640	21
22	Building Improvements			1982	54,612		5-10			54,612	22
23	Building Improvements			1983	65,748		5-10			65,748	23
24	Building Improvements			1984	74,218		5-10			74,218	24
25	Building Improvements			1985	28,402		5-10			28,402	25
26	Building Improvements			1986	53,789		5			53,789	26
27	Garage			1983	11,892		10			11,892	27
28	Brethren - House			1977	19,500		25			19,500	28
29	Brethren - Renovations			1980	40,698		25			40,698	29
30	Brethren - Insulation			1981	2,149		10			2,149	30
31	Brethren - Garage			1984	10,692		10			10,692	31
32	Brethren - Bath Remodel			1986	1,296		5			1,296	32
33	Brethren - Garage Improvement			1980	2,095		14			2,095	33
34	Energy Management			1985	3,180		10			3,180	34
35	Building (28 Beds)			1999	2,780,122	69,503	40	69503		1,190,159	35
36	Carpeting			1989	805		10			805	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pinecrest Manor

0012765

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Canopy Extension	1987	\$ 6,935	\$	5-10	\$	\$	\$ 6,935	37
38 Entrance Way	1987	37,500		25			37,500	38
39 Building Improvements	1991	14,073		5-15			14,073	39
40 Building Improvements	1991	10,796		10-15			10,796	40
41 Capitalized Repairs	1991	1,652		10			1,652	41
42 Building Improvements	1992	5,649		10-20			5,649	42
43 Building Improvements	1992	3,071		10			3,071	43
44 Building Improvements	1992	1,380		15			1,380	44
45 Building Improvements	1993	3,049		10			3,049	45
46 Building Improvements	1993	28,880		5			28,880	46
47 Building Improvements	1994	4,485	117	20		(117)	4,485	47
48 Building Improvements	1994	621		15			621	48
49 Building Improvements	1994	14,328		15			14,328	49
50 Building Improvements	1994	14,178		15			14,178	50
51 Building Improvements	1995	630		15			630	51
52 Garage Improvements	1996	2,516		5			2,516	52
53 Blacktop Resurfacing	1996	4,902		5			4,902	53
54 Blacktop Resurfacing	1997	1,805		5			1,805	54
55 Patio doors	1997	1,285		10			1,285	55
56 Water softener	1997	12,260		10			12,260	56
57 Accordion door	1997	3,295		10			3,295	57
58 Roof repairs	1997	5,162		10			5,162	58
59 Furnace repairs	1997	2,358		10			2,358	59
60 Redecorating	1998	34,716		10			34,716	60
61 Countertop & wallcovering	1998	4,167		5			4,167	61
62 Door	1998	62		5			62	62
63 Paging system	1998	2,977		5			2,977	63
64 Wiring	1998	950		5			950	64
65 Asbestos Removal	1998	79,150		10			79,150	65
66 Redecorating	1999	43,753		10			43,753	66
67 Asbestos Removal	1999	17,255		10			17,255	67
68 Pipe insulation	1999	6,625		10			6,625	68
69 Landscaping	1999	8,310		10			8,310	69
70 TOTAL (lines 4 thru 69)		\$ 5,135,355	\$ 72,441		\$ 72,328	\$ (113)	\$ 3,526,368	70

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

Facility Name & ID Number Pinecrest Manor

0012765

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,135,355	\$ 72,441		\$ 72,328	\$ (113)	\$ 3,526,368	1
2	Signs	1999	10,583	-	5	-		10,583	2
3	Roof	1999	55,935	1,853	15	-	(1,853)	55,935	3
4	Windows	1999	20,688	692	15	-	(692)	20,688	4
5	HVAC Improvement	1999	2,000	71	15	-	(71)	2,000	5
6	Fixed Equipment	1999	80,501	-	5	-		80,501	6
7	Wing 4 addition and modernization	1999	858,673	21,467	40	21,467		370,353	7
8	Kitchen modernization	1999	602,543	15,064	40	15,064		260,553	8
9	Heating & cooling renovation	1999	1,486,082	37,152	40	37,152		640,948	9
10	Fresh air unit	1999	329,276	8,232	40	8,232		142,020	10
11	Emergency/supplemental electricity	1999	219,518	5,488	40	5,488		94,680	11
12	Security system	1999	11,190	280	40	280		5,140	12
13	Retention pond	1999	25,282	632	40	632		10,907	13
14	Sidewalks and outdoor lighting	1999	31,556	789	40	789		13,612	14
15	Additional modernization	2000	42,948	2,147	20	2,147		35,426	15
16	Flooring	2000	22,767	-	5	-		22,767	16
17	Windows	2000	10,325	516	20	516		8,514	17
18	Firewall	2000	39,232	1,962	20	1,962		32,373	18
19	Security system	2000	191	-	10	-		191	19
20	Remodeling	2000	14,848	-	5	-		14,848	20
21	Landscaping	2000	645	-	10	-		645	21
22	Additional asbestos removal	2000	1,200	-	10	-		1,200	22
23	Roofing	2000	2,884	-	10	-		2,884	23
24	Security system & fire alarm system	2000	3,631	-	10	-		3,631	24
25	Additional kitchen modernization	2000	2,756	137	20	137		2,261	25
26	Timeclock & security system	2000	3,283	-	10	-		3,283	26
27	Security and Entrance Doors	2000	24,520	-	10	-		24,520	27
28	Firewall	2000	3,436	-	10	-		3,436	28
29	Additional kitchen modernization	2000	10,361	-	10	-		10,361	29
30	HVAC	2001	2,664	-	10	-		2,664	30
31	Roofing	2001	36,573	2,438	15	2,438		35,351	31
32	Planning for modernization of rehabilitation rooms	2002	1,850	92	20	92		1,334	32
33	Memorial Project	2002	4,542	-	10	-		4,542	33
34	TOTAL (lines 1 thru 33)		\$ 9,097,838	\$ 171,453		\$ 168,724	\$ (2,729)	\$ 5,444,519	34

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

Facility Name & ID Number Pinecrest Manor

0012765

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,097,838	\$ 171,453		\$ 168,724	\$ (2,729)	\$ 5,444,519	1
2	New Roof	2002	90,352	6,023	15	6,023		78,300	2
3	Courtyard Pavillion	2003	16,255	542	15	1,084	542	14,634	3
4	Solarium	2003	184,761	4,619	40	4,619		62,357	4
5	Wing 7 Renovations	2003	57,851	1,446	40	1,446		19,521	5
6				-		-			6
7	Landscaping - Courtyard	2003	56,011	1,868	30	1,868		23,350	7
8	Electrical - Courtyard	2003	27,003	900	30	900		11,250	8
9	Plumbing - Courtyard	2003	5,446	182	30	182		2,275	9
10	Remodeling Solarium Courtyard	2003	76,689	2,556	30	2,556		31,950	10
11	Survey - Courtyard	2003	2,296	76	30	76		950	11
12	Registers - Solarium	2003	3,375	-	5	-		3,375	12
13	Cabinetry - Wing 7	2003	741	18	40	18		225	13
14	Water lines - Main bldg	2003	1,919	95	10	-	(95)	1,919	14
15	Dietary drain flushing system	2003	726	42	10	-	(42)	726	15
16	Communications system - Wing 4	2003	3,729	195	10	-	(195)	3,729	16
17	Kitchen modernization - Wing 7	2003	414	10	40	10		125	17
18	Wallcovering	2003	5,980	299	10	-	(299)	5,980	18
19	Code Alert installation	2004	3,799	-	5	-		3,799	19
20	Fire alarm renovation and upgrade	2004	17,161	-	5	-		17,161	20
21	Time clock upgrade	2004	325	-	5	-		325	21
22				-		-			22
23	Wallpaper/Drapes/Redecorating	2005	6,153	308	20	308		3,542	23
24	Fascia improvements	2005	2,187	110	20	110		1,265	24
25	Wing 6 Tub/Shower	2005	9,024	452	20	452		5,198	25
26	Door Strikes - Pinecrest Terrace	2005	3,091	154	20	154		1,771	26
27	Unitary controller	2005	1,077	54	20	54		621	27
28	New Floats in Sewer Ejector Pit	2005	1,440	72	20	72		828	28
29	Wing 4 - Roof Renovation	2005	39,825		10			39,825	29
30	Renovation - East Dining Room	2005	39,599	1,980	20	1,980		22,770	30
31	Replace circulating pump	2005	1,463	74	20	74		851	31
32	Bathing System & Electric Transfer Seat	2005	9,040	450	20	450		5,175	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		\$ 9,765,570	\$ 193,978		\$ 191,160	\$ (2,818)	\$ 5,808,316	34

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

Facility Name & ID Number Pinecrest Manor

0012765

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,765,570	\$ 193,978		\$ 191,160	\$ (2,818)	\$ 5,808,316	1
2	West doctor's station renovation	2005	1,206	60	20	60		630	2
3	East Lounge renovation	2006	14,637	732	20	732		7,686	3
4	Removal of tile floor	2005	700	35	20	35		368	4
5	Parking lot expansion	2006	53,249	2,662	20	2,662		27,951	5
6	Heat lamps and timers	2006	877	44	20	44		462	6
7	Alarms	2006	1,830	92	20	92		966	7
8	Top jam mounted closer aluminum	2006	1,058	53	20	53		556	8
9				-		-			9
10	13 Vertech Radio VHF-160VC	2006	5,000	-	5	-		5,000	10
11	Seal Coat - Parking Lot	2006	6,101	-	5	-		6,101	11
12	Install Roof Systems - Wing 1 & 6	2006	88,180	4,409	20	4,409		41,886	12
13				-		-			13
14	Compressor	2008	7,077	354	10	708	354	5,309	14
15	Ejector Pump	2008	10,026	501	10	1,002	501	7,515	15
16				-		-			16
17	Employee Lounge Renovation-flooring, cabinetry and electrical	2009	8,612	430	20	430		3,225	17
18	Fire Alarm Upgrade	2009	9,850	493	20	493		3,697	18
19	Courtyard Project	2009	23,992	2,329	10	2,399	70	17,993	19
20	Sidewalk Egress Lighting	2009	21,975	1,099	20	1,099		8,242	20
21				-		-			21
22	Wing 5 Roof	2010	39,535	2,636	15	2,636		15,376	22
23	Water Heater	2011	6,895	690	10	690		3,737	23
24	Sprinkler System	2011	269,493	17,966	15	17,966		95,819	24
25				-		-			25
26	Canopy-Pinecrest Terrace Courtyard	2011	3,400		3			3,400	26
27	Lighting Change throughout Manor-nursing home area	2011	6,309	630	10	630		2,835	27
28	Lighting upgrade throughout Manor-nursing home area	2011	5,248	524	10	524		2,358	28
29	Sidewalk removal & replacement	2012	6,511	651	10	651		2,630	29
30	Smoke Detector	2012	2,750	275	10	275		1,238	30
31	Boiler Repair	2012	5,180	518	10	518		2,331	31
32	AC/RTU Switch and Sensor	2012	2,900	290	10	290		1,305	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		\$ 10,368,161	\$ 231,451		\$ 229,558	\$ (1,893)	\$ 6,076,932	34

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

Facility Name & ID Number Pinecrest Manor

0012765

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,368,161	\$ 231,451		\$ 229,558	\$ (1,893)	\$ 6,076,932	1
2	Mechanical Room-A.O. Smith BTR-275A Water Heater	2012	8,262	826	10	826		2,478	2
3									3
4	Drain repair & new asphalt surfacing, Manor Wesley entrance	2013	10,000	2,000	5	2,000	(0)	5,000	4
5	Annunciator for Fire Alarm System in Front office	2014	3,021	810	3	1,007	197	2,419	5
6	& Accelerator added to sprinkler system								6
7	Hot Water Project	2014	124,784	8,319	15	8,318	(1)	20,795	7
8	Terrace signal units & console alarm system	2014	5,008	1,002	5	1,002	0	2,505	8
9	Repair/replace heat exchange/thermostat in dining room	2014	2,577		15	172	172	430	9
10	Removal of asbestos in boiler room	2014	6,740		15	450	450	1,125	10
11									11
12	Water Softener in mechanical room	2014	15,004	1,250	10	1,500	250	2,250	12
13	Sewer Ejection System, Sewer Slicer throughout facility	2015	22,424	187	10	2,242	2,056	3,364	13
14				-		-			14
15	Security Camera for Surveillance	2016	4,197	583	3	700	117	700	15
16	Carrier RTU	2016	8,395	93	15	280	187	280	16
17				-					17
18				-					18
19				-					19
20	To Reconcile to FS			(12,676)			12,676		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	TOTAL (lines 1 thru 33)		\$ 10,578,573	\$ 233,845		\$ 248,056	\$ 14,212	\$ 6,118,280	34

**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	\$ 372,875	\$ 75,199	\$ 77,704	\$ 2,505	3-15	\$ 259,226	71
72	Current Year Purchases	7,076	1,157	781	(376)	3-5	781	72
73	Fully Depreciated Assets	2,129,490					2,129,490	73
74								74
75	TOTALS	\$ 2,509,441	\$ 76,356	\$ 78,485	\$ 2,129		\$ 2,389,497	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	Long Term Care	94 Dodge Van	1994	\$ 7,355	\$	\$	\$	10	\$ 7,355
77	Long Term Care	95 GMC Safari	1995	17,994	-	-		10	17,994
78	Long Term Care	Ford Elkhart Coach	2007	44,766	4,477	4,477		7	39,014
79	See Sch 13A			90,624	5,527	5,527		5-10	66,511
80	TOTALS			\$ 160,739	\$ 10,004	\$ 10,004	\$		\$ 130,874

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)			\$	13,269,379
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	320,205
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	336,545
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	16,341
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	8,638,651

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 93,613
93		
94		
95		\$ 93,613

* 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.

Facility Name: Pinecrest Manor
IDPH License ID Number: 0012765
Fiscal Year End: 06/30/2016

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Long Term Care	05 Dodge Neon	2008	9,765			-	5	9,765
Maintenance Support	08 Kobota Tractor	2008	28,885	2,889	2,889	-	10	24,557
Long Term Care	Town & Country Van	2011	25,594			-	3	25,594
Long Term Care	13 GMC Sierra Pickup	2013	26,380	2,638	2,638	-	10	6,595
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			90,624	5,527	5,527	-		66,511

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			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. N/A
- This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 6,919 Description: Oxygen Rental
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2017</u>	\$ <u> </u>
13.	<u>/2018</u>	\$ <u> </u>
14.	<u>/2019</u>	\$ <u> </u>

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	39(3)	hrs	\$	2,573	\$ 185,248	\$	2,573	\$ 185,248	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		259	18,640		259	18,640	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,558	328,162		4,558	328,162	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				114,112		114,112	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			\$	7,390	\$ 532,050	\$ 114,112	7,390	\$ 646,162	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 62,747	\$ 62,747	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 410,000)	1,686,928	1,686,928	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,516	87,516	6
7	Other Prepaid Expenses	44,688	44,688	7
8	Accounts Receivable (owners or related parties)	160	160	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,882,039	\$ 1,882,039	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,626	20,626	13
14	Buildings, at Historical Cost	8,585,689	1,373,509	14
15	Leasehold Improvements, at Historical Cost	1,272,888	9,205,064	15
16	Equipment, at Historical Cost	2,789,801	2,670,180	16
17	Accumulated Depreciation (book methods)	(7,986,657)	(8,638,651)	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 CIP)	93,613	93,613	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,775,960	\$ 4,724,341	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,657,999	\$ 6,606,380	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 767,865	\$ 767,865	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	509,313	509,313	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,962	38,962	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	See Sch 17A	599,728	599,728	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,915,868	\$ 1,915,868	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	100,669	100,669	40
41	Bonds Payable	3,830,036	3,830,036	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)	\$ 3,930,705	\$ 3,930,705	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,846,573	\$ 5,846,573	46
47	TOTAL EQUITY(page 18, line 24)	\$ 811,426	\$ 759,807	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,657,999	\$ 6,606,380	48

*(See instructions.)

Facility Name: Pinecrest Manor
IDPH License ID Number: 0012765
Fiscal Year End: 06/30/2016

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
OIG/Hospice Payable	14,157	14,157
Credit Balances A/R	232,963	232,963
Interest Payable	9,447	9,447
Resident Funds Payable	10,348	10,348
Intra-company Accounts Payable	330,475	330,475
Employee w/h - Health	(325)	(325)
Employee w/h - Dental	2,786	2,786
Employee w/h - Aflac	(68)	(68)
Employee w/h - S/L Dis Ins	(55)	(55)
Total - Line 36	599,728	599,728

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,800,445	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,800,445	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(989,016)	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) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (989,019)	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)	\$ 811,426	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pinecrest Manor

0012765

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,232,110	1
2	Discounts and Allowances for all Levels	(3,091,862)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,140,248	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,088,036	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,088,036	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,161	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	109,637	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,505	19
20	Radiology and X-Ray	5,996	20
21	Other Medical Services	66,792	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 217,091	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,064	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,064	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	513,892	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 513,892	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,960,331	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,302,798	31
32	Health Care	3,537,872	32
33	General Administration	2,015,088	33
	B. Capital Expense		
34	Ownership	447,786	34
	C. Ancillary Expense		
35	Special Cost Centers	1,354,947	35
36	Provider Participation Fee	290,856	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,949,347	40
41	Income before Income Taxes (line 30 minus line 40)**	(989,016)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (989,016)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,547,061	44
45	Private Pay - Net Inpatient Revenue	3,963,713	45
46	Medicare - Net Inpatient Revenue	629,474	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,140,248	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.

^-This entity is a cash basis taxpayer

Facility Name:

Pinecrest Manor

IDPH License ID Number:

0012765

Fiscal Year End:

06/30/2016

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Dietary income	14,100
Vending income FY15	13,350
Miscellaneous Rev	617
Finance Charges	(18,175)
Pinecrest Village Mgmt Fee	415,200
Pinecrest Grove Mgmt Fee	88,800
Total - Line 28	513,892

Facility Name & ID Number Pinecrest Manor# 0012765Report Period Beginning: 07/01/2015Ending: 06/30/2016

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	1,824	2,080	\$ 106,193	\$ 51.05	1
2	Assistant Director of Nursing	1,880	2,112	40,679	19.26	2
3	Registered Nurses	36,181	37,871	822,279	21.71	3
4	Licensed Practical Nurses	31,831	33,946	602,264	17.74	4
5	CNAs & Orderlies	144,814	156,193	1,476,061	9.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,862	7,904	135,130	17.10	10
11	Social Service Workers	6,446	7,426	163,829	22.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,869	42,274	479,352	11.34	15
16	Dishwashers					16
17	Maintenance Workers	11,561	13,023	284,213	21.82	17
18	Housekeepers	24,198	27,071	289,076	10.68	18
19	Laundry	14,305	16,261	162,393	9.99	19
20	Administrator	1,872	2,080	106,000	50.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,955	18,210	362,038	19.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care					32
33	Other(specify) <u>See Sch 20A</u>	5,844	6,674	134,310	20.12	33
34	TOTAL (lines 1 - 33)	344,442	373,125	\$ 5,163,817 *	\$ 13.84	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 16,068	1(3)	35
36	Medical Director	Monthly	6,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,698	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,388	11(3)	44
45	Social Service Consultant	Monthly	357	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,111		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	240	\$ 11,053	10(3)	50
51	Licensed Practical Nurses	720	28,064	10(3)	51
52	Certified Nurse Assistants/Aides	209	5,009	10(3)	52
53	TOTAL (lines 50 - 52)	1,169	\$ 44,126		53

Facility Name: Pinecrest Manor
IDPH License ID Number: 0012765
Fiscal Year End: 06/30/2016

Schedule 20A

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Development	1,664	2,080	55,204	\$ 26.54
Marketing	4,180	4,594	79,106	\$ 17.22
Total - Line 33 Other (specify):	5,844	6,674	134,310	\$ 20.12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Ferol Labash	Administrator	0%	\$ 106,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,000
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
Hinshaw & Culbertson LLP	Legal	\$	1,121
Smith & Birkholz PC	Legal		3,991
John Delavan & Assoc LLC	Accounting		27,512
Katherine M McBride	Accounting		56,855
RSM US LLP	Accounting		49,408
ACT Network Solutions, Inc	Computer Services		16,634
MatrixCare AOD	Computer Services		8,999
Matthew J Severns	Computer Services		7,813
Cyberlink	Computer Services		180
Crescendo Interactive Inc.	Computer Services		595
Adobe	Computer Services		323
Monthly Amortization	Computer Services		20,147
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 193,578
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	256,818
Unemployment Compensation Insurance			5,328
FICA Taxes			376,375
Employee Health Insurance			316,291
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Retirement			64,284
Employee Physicals			8,415
Employee Recognition			7,866
Employee Dental Insurance			7,374
Employee Life Insurance			6,756
Other Employee Benefits			10,662
Less: Independent Living & Retirement Comm.			(72,783)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 987,386
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 32)			1,020
Patient Background Checks 164			2,780
LeadingAge IL			1,136
Non Allowable Lobbying			(227)
Chamber of Commerce			125
Miscellaneous Dues & Subs			
Less : Chamber of Commerce Dues			(125)
Less: Public Relations Expense			6,826
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 11,535
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			17,437
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	17,437

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Pinecrest Manor
IDPH License ID Number: 0012765
Fiscal Year End: 06/30/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
From Page 21 Section C		193,578
Total (agree to Schedule V, line 19, column 3)		193,578
Less: Non-Allowable Legal Fees		(1,953)
Total (agree to Schedule V, line 19, column 8)		191,625

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes

LeadingAge-Illinois \$1,136

(3)

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

Yes

Yes

(4)

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

No

N/A

(5)

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

Yes

5.6 Yrs

(6)

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

35,637

10(2)

(7)

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

Yes

(8)

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

No

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES
NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X

N/A

(11)

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

\$

290,856

(12)

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

No

(13)

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

Yes

(14)

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

No

(15)

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

N/A

Yes

14,100

(16)

Travel and Transportation

a.

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

No

b.

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

No

N/A

c.

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

0

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained

e.

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

Yes

f.

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

N/A

g.

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

N/A

N/A

(17)

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

Yes

RSM US LLP

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

Yes