

		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>0034074</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Wetherell Place</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>1026 N Merchant St</u> <u>Effingham</u> <u>62401</u>																									
Number City Zip Code																									
County: <u>Effingham</u>																									
Telephone Number: <u>(217) 342-6621</u> Fax # <u>(217) 342-6687</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>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 rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><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) _____	(Type or Print Name) <u>Pat Devine</u>	(Title) <u>Executive Director</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin 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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Date of Initial License for Current Owners: <u>07/15/88</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>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 _____	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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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: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Wetherell Place

0034074 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	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	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	<u>5,197</u>	<u>366</u>		<u>5,563</u>	13
14	TOTALS	5,197	366		5,563	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.00%

D. How many bed-hold days during this year were paid by the Department?
70 (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 07/15/88

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/07/90 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

ACCRAUAL ☒ 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Wetherell Place # 0034074 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	39,449	5,931	1,125	46,505		46,505		46,505			1
2	Food Purchase		64,016		64,016		64,016		64,016			2
3	Housekeeping	21,571	5,213		26,784		26,784		26,784			3
4	Laundry		2,694		2,694		2,694		2,694			4
5	Heat and Other Utilities			14,106	14,106		14,106		14,106			5
6	Maintenance	11,702	4,412	6,258	22,372		22,372	148	22,520			6
7	Other (specify):*											7
8	TOTAL General Services	72,722	82,266	21,489	176,477		176,477	148	176,625			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	175,979	9,269	25,440	210,688		210,688		210,688			10
10a	Therapy			1,904	1,904		1,904		1,904			10a
11	Activities		4,343	1,168	5,511		5,511		5,511			11
12	Social Services											12
13	CNA Training	21,069			21,069		21,069		21,069			13
14	Program Transportation			5,955	5,955		5,955		5,955			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	197,048	13,612	38,067	248,727		248,727		248,727			16
	C. General Administration											
17	Administrative	12,958			12,958		12,958		12,958			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			2,174	2,174		2,174	49	2,223			20
21	Clerical & General Office Expenses	22,511	2,164	3,179	27,854		27,854	2	27,856			21
22	Employee Benefits & Payroll Taxes			67,850	67,850		67,850	4	67,854			22
23	Inservice Training & Education			7,986	7,986		7,986	3	7,989			23
24	Travel and Seminar			292	292		292		292			24
25	Other Admin. Staff Transportation			1,648	1,648		1,648		1,648			25
26	Insurance-Prop.Liab.Malpractice			5,344	5,344		5,344	842	6,186			26
27	Other (specify):*											27
28	TOTAL General Administration	35,469	2,164	150,878	188,511		188,511	3,837	192,348			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	305,239	98,042	210,434	613,715		613,715	3,985	617,700			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			22,267	22,267		22,267	(421)	21,846			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			134	134		134		134			35
36	Other (specify):*											36
37	TOTAL Ownership			22,401	22,401		22,401	(421)	21,980			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			33,006	33,006		33,006		33,006			42
43	Other (specify):* Disallowed Costs			170	170		170	(170)				43
44	TOTAL Special Cost Centers			33,176	33,176		33,176	(170)	33,006			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	305,239	98,042	266,011	669,292		669,292	3,394	672,686			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	(421)	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	(21)	43		24
25	Fund Raising, Advertising and Promotional	(149)	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)	\$ (591)		\$	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))	\$ 3,394		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
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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 Wetherell Place # 0034074 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 Wetherell Place # 0034074 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	(421)	0	0	0	0	0	0	0	0	0	0	(421)	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	(421)	0	0	0	0	0	0	0	0	0	0	(421)	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):*	(170)	0	0	0	0	0	0	0	0	0	0	(170)	43
44	TOTAL Special Cost Centers	(170)	0	0	0	0	0	0	0	0	0	0	(170)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(591)	3,985	0	0	0	0	0	0	0	0	0	3,394	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

Wetherell Place

0034074

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Wetherell Place

0034074

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 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

		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.				
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.				

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

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 Wetherell Place COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0034074

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: 4,020

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? YES X NO

If so, please complete the following:

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

3. Current Period Amortization:4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	36,043	1990	\$ 22,692	1
2					2
3	TOTALS	36,043		\$ 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	1988	\$ 412,308	\$ 14,165	30	\$ 13,744	\$ (421)	\$ 361,924
5										
6										
7										
8										
	Improvement Type**									
9	Garage, parking lot, sidewalks and landscaping			1988	30,000		15			30,000
10	Paving			1991	2,910		15			2,910
11	Roof repair			1998	4,290	215	20	215		3,933
12	Bathroom remodel, building improvement exterior, sidewalk			2003	13,753	708	5-15yrs	708		12,440
13	Carpet			2005	2,742		5			2,742
14	Retaining wall			2006	5,750	288	20	288		3,163
15	Kitchen Cabinets			2008	6,579	439	15	439		3,729
16	Levolor faux wood blinds			2008	3,496		5			3,496
17	Roof Repair			2009	15,965	1,597	10	1,597		11,708
18	2 Furnaces			2012	4,950	495	10	495		2,351
19	Bathroom Remodel-Shower Floor/Drywall/Tile/Water Lines/									
20	Tub Unit/Faucet			2015	14,082	1,173	12	1,173		1,662
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 Wetherell Place

0034074

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)		\$ 516,825	\$ 19,080		\$ 18,659	\$ (421)	\$ 440,058	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	\$ 59,642	\$ 1,312	\$ 1,312	\$	3-15 yrs	\$ 46,379	71
72	Current Year Purchases	29,595	1,875	1,875		5-15 yrs	1,875	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 89,237	\$ 3,187	\$ 3,187	\$		\$ 48,254	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	2006 Ford E350 Vanterra	2007	\$ 46,600	\$	\$	\$	4 yrs	\$ 46,600
77									77
78									78
79									79
80	TOTALS			\$ 46,600	\$	\$	\$		\$ 46,600

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)			\$	675,354
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	22,267
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	21,846
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(421)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	534,912

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	2001 Ford Van-2001	\$ 20,234	\$	\$ 20,234
87				
88				
89				
90				
91	TOTALS	\$ 20,234	\$	\$ 20,234

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
95		\$

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

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

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
- N/A
- N/A
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: \$ 134
- Description: Miscellaneous
- (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)		21,069		21,069
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 21,069	\$	\$ 21,069
10	SUM OF line 9, col. 1 and 2 (e)	\$ 21,069			

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(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	10,103	10,103	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	578,330	578,330	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 639,753	\$ 639,753	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	529,517	516,825	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	156,071	135,837	16
17	Accumulated Depreciation (book methods)	(566,281)	(534,912)	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)	\$ 129,307	\$ 140,442	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 769,060	\$ 780,195	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,203	\$ 1,203	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,748	8,748	30
31	Accrued Taxes Payable (excluding real estate taxes)	389	389	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)	\$ 10,340	\$ 10,340	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)	\$ 10,340	\$ 10,340	46
47	TOTAL EQUITY(page 18, line 24)	\$ 758,720	\$ 769,855	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 769,060	\$ 780,195	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 788,850	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 788,850	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(30,130)	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)	\$ (30,130)	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)	\$ 758,720	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Wetherell Place

0034074

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	\$ 616,748	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 616,748	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	21,069	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)	\$ 21,069	23
	D. Non-Operating Revenue		
24	Contributions	1,000	24
25	Interest and Other Investment Income***	345	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,345	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)	\$ 639,162	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	176,477	31
32	Health Care	248,727	32
33	General Administration	188,511	33
	B. Capital Expense		
34	Ownership	22,401	34
	C. Ancillary Expense		
35	Special Cost Centers	170	35
36	Provider Participation Fee	33,006	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 669,292	40
41	Income before Income Taxes (line 30 minus line 40)**	(30,130)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (30,130)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 420,099	44
45	Private Pay - Net Inpatient Revenue	196,649	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)	\$ 616,748	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					4
5	CNAs & Orderlies	15,909	16,512	163,972	9.93	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	2,899	2,933	39,449	13.45	15
16	Dishwashers					16
17	Maintenance Workers	1,003	1,083	11,702	10.81	17
18	Housekeepers	1,943	2,038	21,571	10.58	18
19	Laundry					19
20	Administrator	648	693	12,958	18.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,326	1,516	22,511	14.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,552	1,728	33,076	19.14	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)	25,280	26,503	\$ 305,239 *	\$ 11.52	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	\$ 1,125	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	20,776	L10, C3	38
39	Pharmacist Consultant	Monthly	1,153	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	1,904	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	2,261	L10, C3	46
47	Psychological Consultant	Monthly	1,250	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,069		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount
Amber Quance	Administrator	None	\$ 12,958	Workers' Compensation Insurance		\$ 7,575	IDPH License Fee		\$
				Unemployment Compensation Insurance		130	Advertising: Employee Recruitment		825
				FICA Taxes		20,789	Health Care Worker Background Check		192
				Employee Health Insurance		33,916	(Indicate # of checks performed 8)		
				Employee Meals		1,674	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*					
				401k		3,120	Subscriptions		217
				Other Employee Benefits		646	IHCA Dues		912
							Other Licenses & Fees		28
							Indirect costs		49
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense		()
(List each licensed administrator separately.)							Non-allowable advertising		()
							Yellow page advertising		()
B. Administrative - Other							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,223
Description									
N/A									
TOTAL (agree to Schedule V, line 17, col. 3)									
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
RFMS, Inc.	Administrative Services		\$ 33,990				Out-of-State Travel	\$	
LTC Support Services, LLC	Support Services		25,560	N/A					
RSM US LLP	Accounting Services		1,853						
Templin Healthcare Accounting	Accounting Services		1,002				In-State Travel		
							Seminar Expense	292	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)							TOTAL		\$ 292

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

****See instructions.**

Facility Name & ID Number <u>Wetherell Place</u>	STATE OF ILLINOIS # <u>0034074</u>	Report Period Beginning: <u>10/1/15</u>	Ending: <u>9/30/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. 912 IHCA

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 5-15 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,032 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,006
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 1,674 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? None
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
 Firm Name: 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. N/A
 Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT