

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0033936

Facility Name: Seborg Terrace

Address: 3024 Alida Street Rockford 61103
Number City Zip Code

County: Winnebago

Telephone Number: (815) 963-0332 Fax # (815) 963-4668

HFS ID Number:

Date of Initial License for Current Owners: 07/01/88

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Ron Wilson Telephone Number: (309) 343-1550
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/2019 to 3/31/20 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.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Lisa Winnett
(Title) Director of Operations

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seborg Terrace

0033936 Report Period Beginning: 4/1/2019 Ending: 3/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,653			5,653	13
14	TOTALS	5,653			5,653	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.53%

D. How many bed reserve days during this year were paid by the Department?
86 (Do not include bed reserve 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 07/01/1988

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/26/1990 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

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 3/31/20 Fiscal Year: 3/31/20
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seborg Terrace # 0033936 Report Period Beginning: 4/1/2019 Ending: 3/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	37,041	4,832	1,245	43,118		43,118		43,118			1
2	Food Purchase		43,262		43,262		43,262		43,262			2
3	Housekeeping	20,805	5,280		26,085		26,085		26,085			3
4	Laundry		1,410		1,410		1,410		1,410			4
5	Heat and Other Utilities			12,079	12,079		12,079		12,079			5
6	Maintenance	15,447	16,220	19,125	50,792		50,792		50,792			6
7	Other (specify):*											7
8	TOTAL General Services	73,293	71,004	32,449	176,746		176,746		176,746			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	217,764	8,925	8,520	235,209		235,209		235,209			10
10a	Therapy											10a
11	Activities		1,127	1,489	2,616		2,616		2,616			11
12	Social Services											12
13	CNA Training	6,831			6,831		6,831		6,831			13
14	Program Transportation			4,039	4,039		4,039		4,039			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	224,595	10,052	14,048	248,695		248,695		248,695			16
	C. General Administration											
17	Administrative	18,523			18,523		18,523		18,523			17
18	Directors Fees							1,364	1,364			18
19	Professional Services			64,615	64,615		64,615	100	64,715			19
20	Dues, Fees, Subscriptions & Promotions			2,520	2,520		2,520	(254)	2,266			20
21	Clerical & General Office Expenses	9,106	3,868	8,276	21,250		21,250	4	21,254			21
22	Employee Benefits & Payroll Taxes			61,104	61,104		61,104		61,104			22
23	Inservice Training & Education			3,223	3,223		3,223		3,223			23
24	Travel and Seminar			303	303		303		303			24
25	Other Admin. Staff Transportation			1,732	1,732		1,732	1	1,733			25
26	Insurance-Prop.Liab.Malpractice			4,464	4,464		4,464	250	4,714			26
27	Other (specify):*											27
28	TOTAL General Administration	27,629	3,868	146,237	177,734		177,734	1,465	179,199			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	325,517	84,924	192,734	603,175		603,175	1,465	604,640			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			26,566	26,566		26,566	(424)	26,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			26,566	26,566		26,566	(424)	26,142			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			44,664	44,664		44,664		44,664			42
43	Other (specify):* Disallowed Costs			170	170		170	(170)				43
44	TOTAL Special Cost Centers			44,834	44,834		44,834	(170)	44,664			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	325,517	84,924	264,134	674,575		674,575	871	675,446			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	(424)	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	(265)	20		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	(170)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (859)		\$	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)	1,730		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,730		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 871		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

Seborg Terrace

ID# 0033936

Report Period Beginning: 4/1/2019

Ending: 3/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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

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
Frances House, Inc.	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, Inc. (FH 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	18	Director Fees	\$	Frances House, Inc.	100.00%	\$ 1,364	\$ 1,364	1
2	V	19	Professional Services		Frances House, Inc.	100.00%	100	100	2
3	V	26	Property Insurance		Frances House, Inc.	100.00%	250	250	3
4	V	20	Dues, Fees & Subscriptions		Frances House, Inc.	100.00%	11	11	4
5	V	21	Clerical & General Office Exp		Frances House, Inc.	100.00%	4	4	5
6	V	25	Employee Training		Frances House, Inc.	100.00%	1	1	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 1,730	\$ * 1,730	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seborg Terrace# 0033936

Report Period Beginning:

4/1/2019

Ending:

3/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Hawthorne Inn of Danville</u>	<u>Danville</u>				1
2	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Clinton</u>	<u>Clinton</u>				2
3	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Freeport</u>	<u>Freeport</u>				3
4	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Peoria</u>	<u>Peoria</u>				4
5	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Peru</u>	<u>Peru</u>				5
6	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Princeton</u>	<u>Princeton</u>				6
7	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Hawthorne Inn of Freeport, IL</u>	<u>Freeport, IL</u>	<u>Supportive Living Facility</u>	7
8	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Hawthorne Inn of Peoria, IL</u>	<u>Peoria, IL</u>	<u>Assisted Living Facility</u>	8
9	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Hawthorne Inn of Peru, IL</u>	<u>Peru, IL</u>	<u>Assisted Living Facility</u>	9
10	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Geneseo, IL</u>	<u>Geneseo, IL</u>	<u>Asst'd & Ind Living Facility</u>	10
11	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Streator, IL</u>	<u>Streator, IL</u>	<u>Asst'd & Ind Living Facility</u>	11
12	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Danville, IL</u>	<u>Danville, IL</u>	<u>Ind Living Facility</u>	12
13	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Freeport, IL</u>	<u>Freeport, IL</u>	<u>Ind Living Facility</u>	13
14	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Peoria, IL</u>	<u>Peoria, IL</u>	<u>Ind Living Facility</u>	14
15	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Peru, IL</u>	<u>Peru, IL</u>	<u>Ind Living Facility</u>	15
16	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Windmill Manor</u>	<u>Coralville, IA</u>				16
17	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Hawthorne Inn of Rochelle, IL</u>	<u>Rochelle, IL</u>	<u>Assisted Living Facility</u>	17
18	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Casa Willis</u>	<u>Sterling, IL</u>	<u>Woodburn</u>	<u>Sterling, IL</u>	<u>CILA</u>	18
19	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Freeport Terrace</u>	<u>Freeport, IL</u>				19
20	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Gordon Jones Terrace</u>	<u>Lanark, IL</u>				20
21	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Hallam Terrace</u>	<u>Rockford, IL</u>				21
22	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Hammett House</u>	<u>Sterling, IL</u>				22
23	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Kanthak House</u>	<u>Ottawa, IL</u>				23
24	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Olson Terrace</u>	<u>Rockford, IL</u>				24
25	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Ridge Terrace</u>	<u>Freeport, IL</u>				25
26	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Cantebury Place</u>	<u>Rockford, IL</u>				26
27	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Glenwood Villa</u>	<u>Rockford, IL</u>				27
28	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Rockton Court</u>	<u>Rockford, IL</u>				28
29	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Rose House</u>	<u>Moline, IL</u>				29
30	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Seborg Terrace</u>	<u>Rockford, IL</u>				30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seborg Terrace# 0033936

Report Period Beginning:

4/1/2019

Ending:

3/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Smith Square</u>	<u>Moline, IL</u>				1
2	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Stern Square</u>	<u>Sterling, IL</u>				2
3	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Stouffer Terrace</u>	<u>Oregon, IL</u>				3
4	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Lewis Terrace</u>	<u>North Chicago, IL</u>				4
5	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Seymour Terrace</u>	<u>North Chicago, IL</u>				5
6	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Waukegan Terrace</u>	<u>Waukegan, IL</u>				6
7	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Pine Terrace</u>	<u>Waukegan, IL</u>				7
8	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Broadway Terrace</u>	<u>Chicago Heights, IL</u>	<u>Woodgate</u>	<u>Matteson</u>	<u>CILA</u>	8
9	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Carole Lane Terrace</u>	<u>Sauk Village, IL</u>	<u>Thornton</u>	<u>Thornton</u>	<u>CILA</u>	9
10	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Flossmoor Terrace</u>	<u>Flossmoor, IL</u>				10
11	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Ravisloe Terrace</u>	<u>Country Club Hills, IL</u>				11
12	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Spaulding Terrace</u>	<u>Markham, IL</u>				12
13	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Calumet City Terrace</u>	<u>Calumet City, IL</u>				13
14	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Dolton Terrace</u>	<u>Dolton, IL</u>				14
15	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Lynwood Terrace</u>	<u>Lynwood, IL</u>				15
16	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Holland Terrace</u>	<u>South Holland, IL</u>				16
17	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Matteson Court</u>	<u>Matteson, IL</u>				17
18	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Priarie House</u>	<u>Sauk Village, IL</u>				18
19	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Torrence Place</u>	<u>Sauk Village, IL</u>				19
20	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Chambness Square</u>	<u>Bourbannais, IL</u>	<u>Gravlin Square</u>	<u>Bradley, IL</u>	<u>CILA</u>	20
21	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Collins Square</u>	<u>Bradley, IL</u>				21
22	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Dearborn Court</u>	<u>Kankakee, IL</u>				22
23	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>River Court</u>	<u>Kankakee, IL</u>				23
24	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Station Court</u>	<u>Kankakee, IL</u>				24
25	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Eagle Court</u>	<u>Kankakee, IL</u>				25
26	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Kankakee Court</u>	<u>Kankakee, IL</u>				26
27	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Roy Court</u>	<u>Bourbannais, IL</u>				27
28	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Hunt Terrace</u>	<u>Kankakee, IL</u>				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seborg Terrace # 0033936 Report Period Beginning: 4/1/2019 Ending: 3/31/20

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								\$ 1,364	L17, 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	\$ 1,364		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seborg Terrace# 0033936

Report Period Beginning:

4/1/2019Ending: 3/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Frances House, Inc.

Street Address

285 S. Farnham

City / State / Zip Code

Galesburg, IL 61401

Phone Number

(309) 343-1550

Fax Number

(309) 343-2857

	1 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	18	Director Fees	Bed Days Avail-FH only	3,168	17	\$ 22,500	\$	192	\$ 1,364	1
2	19	Professional Services	Bed Days Avail-FH only	3,168	17	1,647		192	100	2
3	26	Property Insurance	Bed Days Avail-FH only	3,168	17	4,119		192	250	3
4	20	Dues, Fees & Subscriptions	Bed Days Available	5,916	33	340		192	11	4
5	21	Clerical & General Office Exp	Bed Days Available	5,916	33	126		192	4	5
6	25	Employee Training	Bed Days Available	5,916	33	20		192	1	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					\$ 28,752	\$		\$ 1,730	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2	N/A												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2020 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:	2015	N/A	8	
	2016	N/A	9	
	2017	N/A	10	
	2018	N/A	11	
	2019	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 2019 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Seborg Terrace COUNTY Winnebago
FACILITY IDPH LICENSE NUMBER 0033936
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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: 4,002

B. General Construction Type: Exterior BrickFrame Wood

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	49,200	1990	\$ 22,692	1
2					2
3	TOTALS	49,200		\$ 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	\$ 14,168	30	\$ 13,744	\$ (424)	\$ 408,877
5										
6										
7										
8										
	Improvement Type**									
9	Garage, Parking Lots and Sidewalks			1988	30,000		15			30,000
10	Water Heater			1997	936		10			936
11	Bathroom and Kitchen Remodeling, Vinyl flooring			2001	9,747		5-15 yrs			9,747
12	Siding and Gutters			2002	7,534		15			7,534
13	Carpeting			2003	999		5			999
14	Wallcovering, Roofing			2004	8,740		5-10 yrs			8,740
15	Roof, Bath/Shower			2005	14,892		7-10 yrs			14,892
16	Carpet, Vinyl			2009	12,700		8			12,700
17	New Furnace			2016	6,700	446	15	446		1,898
18	New Closet doors and closet shelving			2016	2,918	195	15	195		811
19	Bathroom 1 Remodel-Vanity/Cabinet/Tile/Fixtures/Bath/Toilet			2017	16,069	1,339	12	1,339		4,129
20	Bathroom 2 Remodel-Tile/Vanity/Fixtures/Cabinets/Bath/Toilet			2017	16,069	1,339	12	1,339		4,129
21	New Vinyl Tile - Resident Rooms			2018	22,008	2,201	10	2,201		4,218
22	Interior Painting - Wall/Ceilings - Entire Facility			2019	14,009	2,568	5	2,568		2,568
23	Convert Sprinkler System to a Wet System			2020	14,700	102	12	102		102
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

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)		\$ 590,329	\$ 22,358		\$ 21,934	\$ (424)	\$ 512,280	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	\$ 45,790	\$ 3,345	\$ 3,345	\$	3-15 yrs	\$ 31,762	71
72	Current Year Purchases	15,363	863	863		10-12 yrs	863	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 61,153	\$ 4,208	\$ 4,208	\$		\$ 32,625	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 - Wheelchair	2002 E350 Ford Van	2002	\$ 21,849	\$	\$	\$	4	\$ 21,849	76
77										77
78										78
79										79
80	TOTALS			\$ 21,849	\$	\$	\$		\$ 21,849	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 696,023	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,566	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,142	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (424)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 566,754	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Van 1993	\$ 5,918	\$	\$ 5,918	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 5,918	\$	\$ 5,918	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease . 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: \$ 0 Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

138

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		6,831		6,831
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,831	\$	\$ 6,831
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,831			

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

(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.)

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	48,637	48,637	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	4,366,256	4,366,256	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,414,893	\$ 4,414,893	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	600,413	590,329	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	91,528	83,002	16
17	Accumulated Depreciation (book methods)	(585,255)	(566,754)	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)	\$ 116,686	\$ 129,269	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,531,579	\$ 4,544,162	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,102	\$ 16,102	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,482	7,482	30
31	Accrued Taxes Payable (excluding real estate taxes)			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)	\$ 23,584	\$ 23,584	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)	\$ 23,584	\$ 23,584	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,507,995	\$ 4,520,578	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,531,579	\$ 4,544,162	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,397,097	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,397,097	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	110,898	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)	\$ 110,898	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)	\$ 4,507,995	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seborg Terrace

0033936

Report Period Beginning: 4/1/2019

Ending:

3/31/20

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	\$ 778,642	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 778,642	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	6,831	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)	\$ 6,831	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 785,473	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	176,746	31
32	Health Care	248,695	32
33	General Administration	177,734	33
	B. Capital Expense		
34	Ownership	26,566	34
	C. Ancillary Expense		
35	Special Cost Centers	170	35
36	Provider Participation Fee	44,664	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 674,575	40
41	Income before Income Taxes (line 30 minus line 40)**	110,898	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 110,898	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 778,642	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 778,642	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	2,096	2,185	48,519	22.21	4
5	CNAs & Orderlies	12,415	13,240	148,235	11.20	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	3,005	3,233	37,041	11.46	15
16	Dishwashers					16
17	Maintenance Workers	1,009	1,049	15,447	14.73	17
18	Housekeepers	2,000	2,080	20,805	10.00	18
19	Laundry					19
20	Administrator	1,423	1,495	18,523	12.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	640	640	9,106	14.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,936	1,968	27,841	14.15	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)	24,524	25,890	\$ 325,517 *	\$ 12.57	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	\$ 1,245	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,002	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	7,043	L10, C3	46
47	Psychological Consultant	Monthly	475	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,765		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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. 933 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? _____
- (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? 10-12 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,546 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. \$ 44,664
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.

SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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 benefits on Schedule V. \$ 1,260 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.