

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>0040188</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Boyd Avenue Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2024</u> to <u>06/30/2025</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>110 South Boyd Ave</u> <u>Amboy</u> <u>61310</u>			
NumberCityZip Code			
County: <u>Lee</u>			
Telephone Number: <u>815-288-6691</u> Fax # <u>815-288-1636</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>09/17/93</u>			
Type of Ownership:			
☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code _____			
☐ 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:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
Name: <u>Jeff Stauter</u> Telephone Number: <u>815-288-6691</u>			
Email Address: _____			

Facility Name & ID Number

Boyd Avenue Home

#

0040188

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

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		5,840
7	16 TOTALS		5,840

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9
Level of Care	Patient Days by Level of Care and Primary Source of Payment							
	Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total
Medicaid Primary	Medicaid Primary							
8 SNF								8
9 SNF/PED								9
10 ICF								10
11 ICF/DD								11
12 SC								12
13 DD 16 OR LESS	5,110							5,110
14 TOTALS	5,110							5,110

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

87.50%

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

(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)

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started

09/17/93

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

YES

Date

09/17/93

NO

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

YES

NO

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

06/30/2025

Fiscal Year:

06/30/2025

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

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			110	110		110		110			1
2	Food Purchase		56,408		56,408		56,408		56,408			2
3	Housekeeping											3
4	Laundry											4
5	Heat and Other Utilities			14,453	14,453		14,453		14,453			5
6	Maintenance		26,590		26,590		26,590		26,590			6
7	Other (specify):*											7
8	TOTAL General Services		82,998	14,563	97,561		97,561		97,561			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records		15,771	6,410	22,181		22,181		22,181			10
10a	Therapy											10a
11	Activities		1,339		1,339		1,339		1,339			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			9,532	9,532		9,532		9,532			14
15	Other (specify):* Patient Advocate		2,819		2,819		2,819		2,819			15
16	TOTAL Health Care and Programs		19,929	15,942	35,871		35,871		35,871			16
	C. General Administration											
17	Administrative			15,667	15,667		15,667		15,667			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			734	734	4,452	5,186		5,186			20
21	Clerical & General Office Expenses			8,577	8,577		8,577		8,577			21
22	Employee Benefits & Payroll Taxes			213,464	213,464		213,464		213,464			22
23	Inservice Training & Education											23
24	Travel and Seminar				1,359		1,359		1,359			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77	8,450		8,450		8,450			26
27	Other (specify):*											27
28	TOTAL General Administration			238,519	248,251	4,452	252,703		252,703			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)		102,927	269,024	381,683	4,452	386,135		386,135			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,180	8,180		8,180		8,180			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25	25		25		25			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			34	34		34		34			34
35	Rent-Equipment & Vehicles			172	172		172		172			35
36	Other (specify):*											36
37	TOTAL Ownership			8,411	8,411		8,411		8,411			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			88,703	88,703		88,703		88,703			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			88,703	88,703		88,703		88,703			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)		102,927	366,138	478,797	4,452	483,249		483,249			45

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

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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)	\$		\$	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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
		Reference	
1	Political Action Committee Payments	\$ 0	201
2	Other Expenses Related to Lobbying Activities		2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/2025

[illegible]

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
Kreider Services Inc	100	Ashton Terrace Group Home	Ashton			
Kreider Services Inc	100	Boyd/Division/Wasson Group Homes	Amboy			
Kreider Services Inc	100	Franklin Grove/Ottawa/First St Group Home	Franklin Grove/Dixon			
Kreider Services Inc	100	Rachuy Group Home	Stockton			

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 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

#	0040188	Report Period Beginning:	07/01/2024	Ending:	6/30/2025
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Name of Related Organization	
Street Address	
City / State / Zip Code	
Phone Number	()
Fax Number	()

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												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.)

** 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 2024 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 2025 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

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
15	PLUS APPEAL COST FROM LINE 5	\$	15
16	LESS REFUND FROM LINE 6	\$	16
17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Boyd Avenue Home</u>	COUNTY	<u>Lee</u>
---------------	-------------------------	--------	------------

FACILITY IDPH LICENSE NUMBER 0040188

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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:

2184/2184/784

B. General Construction Type:

Exterior

Brick & Vinyl

Frame

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).

F. List the bed capacity for the building if it differs from the licensed total

N/A

G. Have you properly capitalized all major repairs and equipment purchases'

YES

H. Are you presently operating under a sale and leaseback arrangement'

NO

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement'

NO

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)

YES

NO

☒

If YES, please indicate name of the facility,

IDPH license number of this related party and the date the present owners took over

K. 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	Building		1994	\$ 48,286	1
2	Land Improvement		1995	2,079	2
3	TOTALS			\$ 50,365	3

XI. OWNERSHIP COSTS (continued)											
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1994	176,334	\$	\$	25	\$	\$	\$ 176,334	4
5			1994	176,334			25			176,334	5
6			1994	146,555			25			146,555	6
7											7
8											8
	Improvement Type**										
9	Carpet & Vinyl Flooring - Boyd			1995	3,129		10			3,129	9
10	Replacement Roof - Boyd			2008	2,914		10			2,914	10
11	Furnance - Boyd			2010	2,500		15			2,500	11
12	Adjust-A-Gate - Boyd			2012	1,309		5			1,309	12
13	Central Air Conditioner - Boyd			2016	2,225	222	10	222		2,003	13
14	Kohler 14K Generator - Boyd			2019	9,280		5			9,280	14
15	Door Slab - Boyd			2019	1,422	95	15	95		593	15
16	Water Conditioner Pro Series High Efficiency - Boyd			2022	2,400	240	10	240		900	16
17	Kitchen Remodel - Boyd			2024	11,792	991	15	991		1,982	17
18	Fire Door - Boyd			2024	948	63	15	63		126	18
19	Hotpoint Gas Dryer - Boyd			2024	754	94	10	94		188	19
20	Refrigerator - Boyd			2025	1,129	113	10	113		113	20
21	GE Electric Range - Boyd			2025	729	73	10	73		73	21
22	Area, Office, Hall Carpet - Division			2000	2,637		5			2,637	22
23	Replace Furnance - Division			2000	2,425		15			2,425	23
24	Replacement Roof - Division			2007	2,509		10			2,509	24
25	Kohler 14KW Generator - Division			2019	9,008		5			9,008	25
26	Kitchen Remodel - Division			2023	2,274	152	5	152		456	26
27	Blacktop Alley - Wasson			1995	875		10			875	27
28	Carpet - Wasson			2000	2,639		5			2,639	28
29	Solar Panel - Wasson			2005	17,480		10			17,480	29
30	Replacement Roof - Wasson			2007	2,271		10			2,271	30
31	New Bedroom - Wasson			2015	2,584		15			2,584	31
32	Sprinkler Line Repair - Wasson			2017	4,979		5			4,979	32
33	29 Dry Barrell Sprinklers - 6 Wet Sprinklers - Wasson			2017	6,388		10			6,388	33
34	Kohler 14KW Generator - Wasson			2019	8,518		5			8,518	34
35	Replacement Driveway - Wasson			2020	14,385	960	15	960		7,439	35
36	BW 40 Gal Water Heater - Wasson			2020	515		10			515	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

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Replacement Furnace - Wasson	2008	\$ 1,955	\$	15	\$ 15	\$	\$ 1,955	37
38	Sidewalk cut & remove - Wasson	2024	3,685	245	15	245		490	38
39	Kitchen Remodel - Wasson	2025	5,831	389	15	389		389	39
40	Washer - Wasson	2025	782	78	10	78		78	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)		\$ 132,271	\$ 3,715		\$ 3,730	\$	\$ 597,968	70

**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	\$3,154	\$337	\$	\$(337)	10	\$6,670	71
72	Current Year Purchases	2,640	285		(285)	12	117	72
73	Fully Depreciated Assets	37,050				10	5,425	73
74								74
75	TOTALS	\$42,844	\$622	\$	\$(622)		\$12,212	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	Residential Transport	2009 Ford 12 Pass Van	2009	\$46,866	\$	\$	\$	4	\$46,866	76
77			2009	559				4	559	77
78			2017	38,034				4	38,037	78
79										79
80	TOTALS			\$85,459	\$	\$	\$		\$85,462	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)	\$310,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$4,337	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$3,730	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(607)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$695,642	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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: \$
- Description:
- (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					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending
- Annual Rent
12. /2026 \$
13. /2027 \$
14. /2028 \$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

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 CNA50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

HOURS PER CNA80

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)		3,352		3,352
4	Clinical Wages (b)		5,364		5,364
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,716	\$	\$ 8,716
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,716			

- (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.

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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.

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
	Accounts & Short-Term Notes Receivable-			
3	Patients (less allowance)			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):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
	Accrued Taxes Payable			
31	(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)	\$	\$	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)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,177,929	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,177,929	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,548,874	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,548,874	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,629,055	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)	\$ 1,629,055	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)	\$ 4,177,929	24 *

* This must agree with page 17, line 47.

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	\$ 1,624,559	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,624,559	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		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)	\$	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		4,496	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,496	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,629,055	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services		31
32	Health Care		32
33	General Administration		33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	40
41	Income before Income Taxes (line 30 minus line 40)**	1,629,055	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,629,055	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	56

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	166	186	10,104	54.32	3
4	Licensed Practical Nurses	755	848	31,754	37.45	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,041	5,655	131,219	23.20	10
11	Social Service Workers	150	168	5,056	30.10	11
12	Dietician					12
13	Food Service Supervisor	90	101	3,603	35.67	13
14	Head Cook	149	166	4,402	26.52	14
15	Cook Helpers/Assistants	5,041	5,655	131,219	23.20	15
16	Dishwashers					16
17	Maintenance Workers	743	631	32,145	50.94	17
18	Housekeepers	5,041	5,655	131,219	23.20	18
19	Laundry	5,041	5,655	131,219	23.20	19
20	Administrator					20
21	Assistant Administrator	3,054	3,454	110,113	31.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	1,797	2,019	58,165	28.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	5,041	5,655	131,219	23.20	30
31	Medical Records					31
32	Other Health Care <u>Patient Advocate</u>	91	101	5,571	55.16	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	32,200	35,949	\$ 917,008 *	\$ 25.51	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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) _____				46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)		\$		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	Ownership %	Amount		
P. Howard	Manager		\$ 21,083		
B. Jilerda	Supervisor		50,300		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,383		
B. Administrative - Other					
Description			Amount		
Allocation of Mgt & General			\$ 15,270		
Consultant Expense - Legal					
Consultant Expense - Other					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 15,270		
C. Professional Services					
Vendor/Payee	Type		Amount		
			\$		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 4,903		
Unemployment Compensation Insurance					
FICA Taxes			57,536		
Employee Health Insurance			148,627		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
403B Pension Plan			2,398		
Tuition Reimbursement					
Christmas Gift/Party			4		
Physical Exam			7		
Accrued Vacation Pay					
Trf to Capital - Maintenance					
TOTAL (agree to Schedule V, line 22, col.8)			\$ 213,475		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description		Line #	Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$		
Advertising: Employee Recruitment					
Health Care Worker Background Check (Indicate # of checks performed)					
Patient Background Checks					
Association Dues (total from pg 22, #4)			26		
DOT Physical			663		
Misc					
Subscriptions			4,188		
Less: Public Relations Expense		(			
PAC and Lobbying payments		(			
All non-allowable advertising		(			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 4,877		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense					
Entertainment Expense		(			
TOTAL (agree to Sch. V, line 24, col. 8)			\$		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number **Boyd Avenue Home**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the association.

Association Name	Amount
<u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u>	<u>26</u>
	26 Total

- (3)** List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)				
				Total

- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)		26
		26 Total

- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ **We do not track** Line **10 Col 2**

- (6)** Have all costs reported on this form been determined using accounting procedure consistent with prior reports? **YES** If NO, attach a complete explanation.

- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. § 88,703
This amount is to be recorded on line 42 of Schedule V.

- (8)** 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.

- (9) 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? **N/A**

- (10) 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? N/A 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.

- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$

- (12) 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. \$
- c. What percent of all travel expense relates to transportation of nurses and patients'
- 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? YES**
Indicate the amount of income earned from providing such transportation during this reporting period. \$

- (13) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: **Lauterbach & Amen**

- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **N/A**

- (15) 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