FOR BHF USE

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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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0038208

Facility Name: ANDOVER

Address: 4636 WEST ANDOVER DRIVE (Number) PEORIA (City) 61615 (Zip Code)

County: PEORIA

Telephone Number: 309 691-3800 **Fax #** 309 689-3613

HFS ID Number:

Date of Initial License for Current Owners: 6/4/93,5/25/93,5/28/93,6/4/93

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STUART SCHMITT **Telephone Number:** 309 691-3800
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 07/01/09 to 06/30/10 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) _____ (Date)
(Type or Print Name) STUART SCHMITT
(Title) VICE PRESIDENT/CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) 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

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	16	Intermediate/DD	16	5,840	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,761			5,761	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,761			5,761	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.65%

D. How many bed-hold days during this year were paid by the Department?
45 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started see dates of initial license

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	3,013	1,640	5,923	10,576	37,069	47,645		47,645			1
2	Food Purchase		52,455		52,455		52,455		52,455			2
3	Housekeeping		3,996	1,474	5,470	5,373	10,843	624	11,467			3
4	Laundry		1,394	57	1,451		1,451		1,451			4
5	Heat and Other Utilities			17,650	17,650		17,650	1,917	19,567			5
6	Maintenance	12,083	6,999	7,674	26,756		26,756	1,551	28,307			6
7	Other (specify):*		3	3,675	3,678		3,678	258	3,936			7
8	**TOTAL General Services**	15,096	66,487	36,453	118,036	42,442	160,478	4,350	164,828			8
	B. Health Care and Programs											
9	Medical Director			450	450		450		450			9
10	Nursing and Medical Records	495,359	5,466	15,882	516,707	(42,442)	474,265		474,265			10
10a	Therapy	6,814		1,811	8,625		8,625		8,625			10a
11	Activities		21	1,562	1,583		1,583		1,583			11
12	Social Services											12
13	CNA Training	2,880	100	960	3,940		3,940	219	4,159			13
14	Program Transportation			14,706	14,706		14,706		14,706			14
15	Other (specify):*			151	151		151		151			15
16	**TOTAL Health Care and Programs**	505,053	5,587	35,522	546,162	(42,442)	503,720	219	503,939			16
	C. General Administration											
17	Administrative	14,480			14,480		14,480	33,770	48,250			17
18	Directors Fees											18
19	Professional Services							8,677	8,677			19
20	Dues, Fees, Subscriptions & Promotions			2,004	2,004		2,004	1,152	3,156			20
21	Clerical & General Office Expenses	5,559	2,140	6,529	14,228	3,513	17,741	24,480	42,221			21
22	Employee Benefits & Payroll Taxes			132,706	132,706		132,706	12,847	145,553			22
23	Inservice Training & Education							1,002	1,002			23
24	Travel and Seminar			715	715		715	12	727			24
25	Other Admin. Staff Transportation							684	684			25
26	Insurance-Prop.Liab.Malpractice			7,837	7,837		7,837	809	8,646			26
27	Other (specify):*			73	73		73	504	577			27
28	**TOTAL General Administration**	20,039	2,140	149,864	172,043	3,513	175,556	83,937	259,493			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	540,188	74,214	221,839	836,241	3,513	839,754	88,506	928,260			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.

Facility Name & ID Number ANDOVER #0038208 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,158	21,158		21,158	9,135	30,293			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,062	2,062		2,062	4,518	6,580			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,154	5,154	(3,513)	1,641	970	2,611			35
36	Other (specify):*							82	82			36
37	**TOTAL Ownership**			28,374	28,374	(3,513)	24,861	14,705	39,566			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			59,032	59,032		59,032		59,032			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			59,032	59,032		59,032		59,032			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	540,188	74,214	309,245	923,647		923,647	103,211	1,026,858			45

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

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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				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	(182)	V20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (182)		$	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)	103,393		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 103,393		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 103,211		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ANDOVER

ID# 0038208

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ANDOVER # 0038208 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ANDOVER # 0038208 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PARC, Inc.	100	NONE		SEE ATTACHMENT		

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		SEE SCH. VIII	$	PARC, Inc.	100.00%	$ 103,393	$ 103,393	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			$			$ 103,393	$ * 103,393	14

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

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		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

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [x] NO [ ]

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

Name of Related Organization: PARC, Inc.
Street Address: 1913 W. Townline Rd., P. O. Box 3418
City / State / Zip Code: Peoria, IL 61612
Phone Number: (309 691-3800
Fax Number: (309 689-3613

	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	3	HOUSEKEEPING	% OF DIRECT COST	10,983,292	9	$ 7,590	$	902,489	$ 624	1
2	5	HEAT & OTHER UTILITIES	% OF DIRECT COST	10,983,292	9	23,329		902,489	1,917	2
3	6	MAINTENANCE	% OF DIRECT COST	10,983,292	9	18,881	10,833	902,489	1,551	3
4	7	OTHER GENERAL SERVICES	% OF DIRECT COST	10,983,292	9	3,140		902,489	258	4
5	10	NURSING & MEDICAL	% OF DIRECT COST	10,983,292	9	5		902,489	0	5
6	13	STAFF TRAINING	% OF DIRECT COST	10,983,292	9	2,665		902,489	219	6
7	17	ADMIN SALARIES	% OF DIRECT COST	10,983,292	9	410,981	410,981	902,489	33,770	7
8	19	PROFESSIONAL FEES	% OF DIRECT COST	10,983,292	9	105,594		902,489	8,677	8
9	20	FEES & SUBSCRIPTIONS	% OF DIRECT COST	10,983,292	9	16,233		902,489	1,334	9
10	21	CLERICAL & GENERAL	% OF DIRECT COST	10,983,292	9	297,927	239,159	902,489	24,480	10
11	22	EMPLOYEE BENEFITS/TAXES	% OF DIRECT COST	10,983,292	9	156,352		902,489	12,847	11
12	23	INSERVICE TRAINING	% OF DIRECT COST	10,983,292	9	12,189		902,489	1,002	12
13	24	TRAVEL & SEMINAR	% OF DIRECT COST	10,983,292	9	143		902,489	12	13
14	25	VEHICLE COST	% OF DIRECT COST	10,983,292	9	8,322		902,489	684	14
15	26	INSURANCE	% OF DIRECT COST	10,983,292	9	9,844		902,489	809	15
16	27	MISCELLANEOUS	% OF DIRECT COST	10,983,292	9	6,129		902,489	504	16
17	30	DEPRECIATION	% OF DIRECT COST	10,983,292	9	111,169		902,489	9,135	17
18	32	INTEREST	% OF DIRECT COST	10,983,292	9	54,985		902,489	4,518	18
19	35	EQUIPMENT RENTAL	% OF DIRECT COST	10,983,292	9	11,803		902,489	970	19
20	36	LOSS ON DISPOSITION	% OF DIRECT COST	10,983,292	9	994		902,489	82	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,258,275	$ 660,973		$ 103,393	25

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	ILLINOIS FINANCE AUTHORITY		X	BOND FINANCING OF	$33,881.00	6/22/07	$ 5,392,530	$ 4,775,922	7/1/2027	4.6800	$ 227,374	1
2				FACILITY THAT INCLUDES								2
3				CORPORATE OFFICES								3
4	HEWLETT-PACKARD			Capital lease - computer equip.	$1,634.00						3,687	4
5	DELAGE LANDEN			Capital lease - forklift	$540.00						876	5
	Working Capital											
6	SOUTH SIDE BANK		X	GENERAL - LINE OF CREDIT		8/29/2009	2,000,000		8/29/2010	VARIABLE	8,848	6
7							(available)					7
8												8
9	TOTAL Facility Related				$36,055.00		$ 7,392,530	$ 4,775,922			$ 240,785	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,392,530	$ 4,775,922			$ 240,785	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **none** **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.)**

Facility Name & ID Number ANDOVER # 0038208 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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.		$ NONE	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ANDOVER COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0038208

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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? YES NO

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 a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,000 B. General Construction Type: Exterior VINYL Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		57,880	1992	$ 63,900	1
2					2
3	TOTALS	57,880		$ 63,900	3

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1992	$ 537,233	$ 13,431	40	$ 13,431	$	$ 287,420	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ARCHITECT FEES			1994	1,769	44	40	44		876	9
10	LANDSCAPING			1995	2,000		10			2,000	10
11	LANDSCAPING & PATIOS			1998	7,885		10			7,885	11
12	CARPET			2003	1,182	118	10	118		886	12
13	FURNACE			2005	1,994	100	20	100		548	13
14	SIDEWALK			2010	3,264	163	10	163		163	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		$ 555,327	$ 13,856		$ 13,856	$	$ 299,778	70

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

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 23,610	$ 2,641	$ 2,641	$	5-20	$ 16,543	71
72	Current Year Purchases	4,040	295	295		5-10	295	72
73	Fully Depreciated Assets	1,595				5	1,595	73
74								74
75	TOTALS	$ 29,245	$ 2,936	$ 2,936	$		$ 18,433	75

D. Vehicle Depreciation (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	Resident activities &	2002 Dodge Caravan	2003	$ 24,929	$	$	$	4	$ 24,929	76
77	care-related transport.	2000 Dodge Caravan	2000	30,708				4	30,708	77
78										78
79										79
80	TOTALS			$ 55,637	$	$	$		$ 55,637	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)	$ 704,109	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,792	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 16,792	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 373,848	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.

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE

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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 2,611 Description: CABLE TV
(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

* 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.

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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? [x] 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 [x]
- HOURS PER CNA 60

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 60

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$ 900	$	$ 900
2	Books and Supplies			100		100
3	Classroom Wages	(a)		1,440		1,440
4	Clinical Wages	(b)		1,440		1,440
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests			60		60
9	TOTALS		$	$ 3,940	$	$ 3,940
10	SUM OF line 9, col. 1 and 2	(e)	$ 3,940			

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.

Facility Name & ID Number ANDOVER

STATE OF ILLINOIS
0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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			$		$	$		$ NONE	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.

STATE OF ILLINOIS

Facility Name & ID Number ANDOVER **#** 0038208 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/10 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 582,875	1
2	Cash-Patient Deposits		87,989	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,963,560	3
4	Supply Inventory (priced at COST)		5,614	4
5	Short-Term Investments			5
6	Prepaid Insurance		44,390	6
7	Other Prepaid Expenses		33,067	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 3,717,495	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		486,863	12
13	Land		626,815	13
14	Buildings, at Historical Cost		7,728,521	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,530,708	16
17	Accumulated Depreciation (book methods)		(5,035,443)	17
18	Deferred Charges		179,847	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):		1,675,263	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 7,192,574	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 10,910,069	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 2,821,705	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		87,989	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		354,815	30
31	Accrued Taxes Payable (excluding real estate taxes)		25,455	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation		27,533	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)**	$	$ 3,317,497	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		4,760,668	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Obligations under capital lease		58,894	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,819,562	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 8,137,059	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,773,010	$ 2,773,010	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,773,010	$ 10,910,069	48

***(See instructions.)**

Facility Name & ID Number ANDOVER **#** 0038208 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,267,397	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,267,397	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	488,386	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) **change in net assets of related entity**	17,227	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 505,613	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)**	$ 2,773,010	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,070,722	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,070,722	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	5,750	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)**	$ 5,750	23
	D. Non-Operating Revenue		
24	Contributions	8,692	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,692	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ALLOCATION FROM SUPPORT SERVICES	8,706	28
28a	ALLOCATION FROM CENTRAL OFFICE	7,213	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,919	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,101,083	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	164,828	31
32	Health Care	503,939	32
33	General Administration	259,493	33
	B. Capital Expense		
34	Ownership	39,566	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	59,032	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,026,858	40
41	**Income before Income Taxes (line 30 minus line 40)****	74,225	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 74,225	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	346	393	7,904	20.11	3
4	Licensed Practical Nurses	557	633	10,819	17.09	4
5	CNAs & Orderlies	345	392	4,139	10.56	5
6	CNA Trainees	360	360	2,880	8.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	391	444	6,814	15.35	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	103	117	1,589	13.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	157	178	1,424	8.00	15
16	Dishwashers					16
17	Maintenance Workers	994	1,130	12,083	10.69	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	509	578	14,480	25.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	408	464	5,559	11.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,924	2,186	32,535	14.88	28
29	Resident Services Coordinator	4,395	4,994	66,027	13.22	29
30	Habilitation Aides (DD Homes)	32,041	36,410	373,935	10.27	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	42,530	48,279	$ 540,188 *	$ 11.19	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	133	$ 5,923	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	6	450	9-3	39
40	Physical Therapy Consultant	2	138	10a-3	40
41	Occupational Therapy Consultant	20	1,673	10a-3	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)	161	$ 8,184		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2	73	10-3	51
52	Certified Nurse Assistants/Aides	878	14,892	10-3	52
53	TOTAL (lines 50 - 52)	880	$ 14,965		53

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ERIC SUTTER	VP/RESIDENTIAL SER.	0	$ 7,486
MIKE PREDMORE	VP/PROGRAM SER.	0	6,104
DORIS HAYES	VP/REHAB. SER.	0	254
BRET STONE	VP/MAINTENANCE	0	636
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 14,480

B. Administrative - Other

Description	Amount
NONE	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NONE		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,234
Unemployment Compensation Insurance	4,723
FICA Taxes	43,336
Employee Health Insurance	76,812
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Retirement Plan	885
Life & Disability Insurance	3,563
TOTAL (agree to Schedule V, line 22, col.8)	$ 145,553

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	522
Health Care Worker Background Check	323
(Indicate # of checks performed 20)	
Patient Background Checks 0	0
Employee Certifications	15
Membership Dues	713
Subscriptions	1,536
Reference Publications	35
Food & Drink License	11
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,155

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	356
Seminar Expense	371
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 727

**See instructions.

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NONE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ANDOVER **#** 0038208 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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? NO
If YES, give association name and amount.

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

(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? 6.85

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(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.

(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. $ 59,032
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? UNK.
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? YES
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. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

2010 FINANCIAL AND STATISTICAL REPORT FOR
LONG TERM CARE FACILITIES

Schedule V. - COST CENTER EXPENSES

Schedule of Reclassifications

1. $42,442 is moved from the Nursing and Medical Records line to the Dietary and Housekeeping lines. No staff working at the residences are hired solely to perform support functions. Direct care staff are assigned responsibility for them. The reclassification is the estimated staff cost to perform dietary and housekeeping functions.

2. $3,513 of the cost of equipment rentals for copiers and pagers is reclassified from line 35 to line 21.

Detail of costs included on Sch. V., line 7

-mowing and grounds maintenance	3,132
-waste disposal	543
-decorating supplies	3
Total	3,678

2010 FINANCIAL AND STATISTICAL REPORT FOR
LONG TERM CARE FACILITIES

SCH. VII. - Other Related Business Entities	CITY	TYPE OF BUSINESS
PARC, Inc.	Peoria	Not-for Profit Corp.
PARC Foundation of Central Illinois, Inc.	Peoria	Not-for Profit Corp.
PARC Developmental Homes, Inc.	Peoria	Not-for Profit Corp.
PARC Residential Options, Inc.	Peoria	Not-for Profit Corp.
PARC Apartments Project, Inc.	Peoria	Not-for Profit Corp.
PARC Community Homes, Inc.	East Peoria	Not-for Profit Corp.
PARC Place, Inc.	Peoria	Not-for Profit Corp.
PARC Group Home, Inc.	Peoria	Not-for Profit Corp.