

		FOR BHF USE					

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**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)**

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.

<p>I. IDPH License ID Number: <u>0037721</u></p> <p>Facility Name: <u>GROUP HOME #6</u></p> <p>Address: <u>320 BACHMAN</u> <u>GODFREY</u> <u>62035</u> <small>Number City Zip Code</small></p> <p>County: <u>MADISON</u></p> <p>Telephone Number: <u>(618) 466-0367</u> Fax # <u>(618) 466-3652</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/21/1992</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BRENDA MILLER</u> Telephone Number: <u>(618) 466-0367</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2013</u> to <u>6/30/2014</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;"> (Signed) _____ (Type or Print Name) <u>MARTHA WARFORD</u> (Title) <u>EXECUTIVE DIRECTOR</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;"> (Signed) _____ (Print Name and Title) <u>KIMBERLY S. LOY</u> <u>PRINCIPAL</u> (Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>106 W. COUNTY ROAD, JERSEYVILLE, IL 62052</u> (Telephone) <u>(618) 498-6841</u> Fax # <u>(618) 498-6842</u> </td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MARTHA WARFORD</u> (Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>KIMBERLY S. LOY</u> <u>PRINCIPAL</u> (Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>106 W. COUNTY ROAD, JERSEYVILLE, IL 62052</u> (Telephone) <u>(618) 498-6841</u> Fax # <u>(618) 498-6842</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MARTHA WARFORD</u> (Title) <u>EXECUTIVE DIRECTOR</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>KIMBERLY S. LOY</u> <u>PRINCIPAL</u> (Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>106 W. COUNTY ROAD, JERSEYVILLE, IL 62052</u> (Telephone) <u>(618) 498-6841</u> Fax # <u>(618) 498-6842</u>							

Facility Name & ID Number GROUP HOME #6

0037721 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,411	194		5,605
14	TOTALS	5,411	194		5,605

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.98%

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

64 (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

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 02/21/1992

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

YES Date 02/21/1992 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2014 Fiscal Year: 6/30/2014

* 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	2,442	361		2,803		2,803	2,803		1	
2	Food Purchase		26,549		26,549		26,549	26,549		2	
3	Housekeeping	34,096	2,604		36,700		36,700	36,700		3	
4	Laundry									4	
5	Heat and Other Utilities			11,457	11,457		11,457	11,457		5	
6	Maintenance	17,917	1,705	6,845	26,467		26,467	26,467		6	
7	Other (specify):* SECURITY	2,395	42	4,226	6,663		6,663	6,663		7	
8	TOTAL General Services	56,850	31,261	22,528	110,639		110,639	110,639		8	
	B. Health Care and Programs										
9	Medical Director									9	
10	Nursing and Medical Records	222,584	5,712		228,296	(9,735)	218,561	218,561		10	
10a	Therapy									10a	
11	Activities	4,798	1,127	156	6,081		6,081	6,081		11	
12	Social Services									12	
13	CNA Training					9,735	9,735	9,735		13	
14	Program Transportation	7,419			7,419		7,419	7,419		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	234,801	6,839	156	241,796		241,796	241,796		16	
	C. General Administration										
17	Administrative	24,689		5,374	30,063	5,468	35,531	35,531		17	
18	Directors Fees									18	
19	Professional Services			11,101	11,101		11,101	11,101		19	
20	Dues, Fees, Subscriptions & Promotions			4,549	4,549		4,549	4,549		20	
21	Clerical & General Office Expenses	30,490	2,430	7,324	40,244		40,244	40,244		21	
22	Employee Benefits & Payroll Taxes			84,219	84,219		84,219	84,219		22	
23	Inservice Training & Education			450	450		450	450		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			4,591	4,591		4,591	4,591		26	
27	Other (specify):*									27	
28	TOTAL General Administration	55,179	2,430	117,608	175,217	5,468	180,685	180,685		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	346,830	40,530	140,292	527,652	5,468	533,120	533,120		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

GROUP HOME #6

#0037721

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			23,478	23,478		23,478		23,478			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,671	31,671	(5,866)	25,805	(25,805)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS.			2,256	2,256	398	2,654		2,654			36
37	TOTAL Ownership			57,405	57,405	(5,468)	51,937	(25,805)	26,132			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			36,208	36,208		36,208		36,208			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,208	36,208		36,208		36,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	346,830	40,530	233,905	621,265		621,265	(25,805)	595,460			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(25,805)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				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)	\$ (25,805)		\$	30

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
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (25,805)		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

BHF USE ONLY						
48		49		50		51
						52

GROUP HOME #6

ID# 0037721

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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 GROUP HOME #6# 0037721

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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 GROUP HOME #6# 0037721

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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

	Capital Expense	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)	
	D. Ownership													
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	(25,805)	0	0	0	0	0	0	0	0	0	0	(25,805)	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	(25,805)	0	0	0	0	0	0	0	0	0	0	(25,805)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(25,805)	0	0	0	0	0	0	0	0	0	0	(25,805)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BEVERLY FARM FOUNDATION	GODFREY			
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #5	GODFREY			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

Facility Name & ID Number

GROUP HOME #6

0037721

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Barry Allswang	BOD						1
2	Brian Birnbaum	BOD						2
3	Hartley Carlton	BOD						3
4	Patricia Downey	BOD						4
5	David Durand	BOD						5
6	Nicholas Lynn	BOD						6
7	William McMahan	BOD						7
8	Donald Perozzi	BOD						8
9	Roger Queen	BOD						9
10	Jeffrey Rosignol	BOD						10
11	Steven Schmidt	BOD						11
12	Glenn Tiller	BOD						12
13	George Walker	BOD						13
14	Pamela Whisler	BOD						14
15	Keith Wright	BOD						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

Facility Name & ID Number GROUP HOME #6 # 0037721 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	BOARD OF DIRECTORS	BOD	BOD	0.00	NONE	7	0.00		\$ 0	NA	1
2	(SEE PAGE 6)										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 GROUP HOME #6

0037721

Report Period Beginning:

7/1/2013

Ending:

7/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization BEVERLY FARM FOUNDATION & GROUP HOMES #1 - #5
 Street Address GODFREY, IL 62035
 City / State / Zip Code (618) 466-0367
 Phone Number (618) 466-3652
 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	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	\$ 3,741,403	\$ 225	\$ 84,219	1
2	17-3	SCHOOL REIMBURSEMENT	WAGES	10,000	8	179,505	277	4,979	2
3	17-1	ADMINISTRATIVE SALARIES	HOURS	2,080	8	223,710	223,710	11,186	3
4	17-3	ADMINISTRATIVE - OTHER	HOURS	2,080	8	79,091	10	395	4
5	21-1	PERSONNEL/ACCOUNTING	HOURS	2,080	8	609,802	104	30,490	5
6	6-1	MAINTENANCE STAFF	HOURS	2,080	8	358,348	358,348	17,917	6
7	7-3	SECURITY/SAFETY	HOURS	2,080	8	84,522	104	4,226	7
8	7-1	SAFETY MANAGER	HOURS	2,080	8	47,894	47,894	2,395	8
9	7-2	SECURITY SUPPLIES	HOURS	2,080	8	847	104	42	9
10	6-2	MAINTENANCE SUPPLIES	HOURS	2,080	8	34,101	104	1,705	10
11	21-2	OSHA REQUIREMENTS	HOURS	2,080	8	41,650	104	2,083	11
12	21-3	CONSULTANTS	HOURS	2,080	8	127,259	104	6,363	12
13	6-3	MAINTENANCE - OTHER	HOURS	2,080	8	111,600	104	5,580	13
14	26-3	INSURANCE	HOURS	2,080	8	91,829	104	4,591	14
15	19-3	LEGAL & ACCOUNTING	HOURS	2,080	8	247,477	93	11,101	15
16	14-1	TRANSPORTATION STAFF	HOURS	2,080	8	148,372	148,372	7,419	16
17	20-3	DUES/SUBS/ADVERTISING	HOURS	2,080	8	134,064	71	4,549	17
18	36-3	MORTGAGE INSURANCE	HOURS	2,080	8	45,122	104	2,256	18
19	32-3	INTEREST	HOURS	2,080	8	633,421	104	31,671	19
20	23-3	INSERVICE TRAINING	HOURS	2,080	8	9,833	95	450	20
21	11-1	ACTIVITIES STAFF	HOURS	2,080	8	95,969	95,969	4,798	21
22	11-2	ACTIVITIES SUPPLIES	HOURS	2,080	8	6,976	104	349	22
23	11-3	ACTIVITIES OTHER	HOURS	2,080	8	3,123	104	156	23
24									24
25	TOTALS					\$ 7,055,918	\$ 874,293	\$ 238,920	25

Facility Name & ID Number

GROUP HOME #6

0037721

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	GRESHMAN MORTGAGE		X	REFINANCE BONDS	\$3,048.00	07/01/10	\$ 497,765	\$	08/01/31	0.0477	\$ 5,458	1						
2	GRESHMAN MORTGAGE		X	REFINANCE BONDS	\$2,946.00	09/19/13	460,755	449,861	08/01/32	0.0417	13,163	2						
3	AMORTIZATION OF DEBT COSTS		X								312	3						
4	LOSS ON BOND RETIREMENT		X								6,872	4						
5												5						
	Working Capital																	
6	LIBERTY BANK		X	WORKING CASH		04/21/14			04/21/15	0.0500		6						
7												7						
8												8						
9	TOTAL Facility Related				\$5,994.00		\$ 958,520	\$ 449,861			\$ 25,805	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 958,520	\$ 449,861			\$ 25,805	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 2,654 Line # 36-8

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 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 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009 _____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010 _____	9																	
	2011 _____	10																	
	2012 _____	11																	
	2013 _____	12																	

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROUP HOME #6 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0037721

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 2013 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 2013.

	(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? 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 GROUP HOME #6

0037721 Report Period Beginning:

7/1/2013 Ending:

6/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,112 B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories ONE

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. 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>	<u>10,000</u>		<u>\$ 5,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	10,000		\$ 5,000	3

Facility Name & ID Number GROUP HOME #6

0037721

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16			1992	\$ 317,200	\$ 7,930	40	\$ 7,930	\$	\$ 177,165	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		BUILDING IMPROVEMENTS		1993	6,822	171	40	171		3,667	9
10		BUS SHELTER		1996	188		5			188	10
11		LAWN WORK		1996	1,811		5			1,811	11
12		ADMINISTRATION BUILDING		1997	55,609	1,391	40	1,391		24,329	12
13		CARPET		1998	14,731		5			14,731	13
14		HARDWARE		1998	546		10			546	14
15		SECURITY SYSTEM		1998	171		10			171	15
16		DOORS		2000	2,681		5			2,681	16
17		FIRE ALARM PANEL		2002	76		10			76	17
18		DIGITAL THERMOMETER		2003	777		10			777	18
19		SPRINKLER		2003	1,242	62	10	62		1,242	19
20		DOOR FRAME		2003	2,100	105	10	105		2,100	20
21		FLOORING		2004	6,283	314	10	314		6,283	21
22		TILE FLOORING - SWITCHBOARD AREA		2005	63	6	10	6		60	22
23		TRAINING BUILDING ALLOCATION		1998	1,481	35	15	35		1,458	23
24		CARPETING - LIVING ROOM & OFFICE		2006	2,523	252	10	252		2,144	24
25		DOORS		2007	3,459	346	10	346		2,767	25
26		DOOR		2008	1,599	160	10	160		1,039	26
27		FLOORING		2009	6,910	1,382	5	1,382		6,220	27
28		DOOR		2013	897	90	10	90		135	28
29		SPRINKLER		2013	4,209	421	10	421		631	29
30		GYM FLOOR		2013	94	19	5	19		28	30
31		7 WINDOWS		2013	146	15	10	15		22	31
32		BATHROOM		2013	192	38	5	38		58	32
33		LIGHTING		2013	370	74	5	74		111	33
34		SEWER REPAIRS		2013	1,062	106	10	106		159	34
35		SPRINKLERS		2013	22	2	10	2		3	35
36		WALL REPAIR MATERIALS		2013	197	39	5	39		59	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 GROUP HOME #6

0037721

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	DOORS	2013	\$ 176	\$ 35	5	\$ 35	\$	\$ 53	37
38	SECURITY CAMERAS	2013	704	141	5	141		211	38
39	COOLING	2013	61	12	5	12		18	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)		\$ 434,402	\$ 13,146		\$ 13,146	\$	\$ 250,943	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	\$ 53,057	\$ 5,741	\$ 5,741	\$	5-10	\$ 31,579	71
72	Current Year Purchases	10,201	1,015	1,015		5-10	1,015	72
73	Fully Depreciated Assets	94,615				5-10	94,615	73
74								74
75	TOTALS	\$ 157,873	\$ 6,756	\$ 6,756	\$		\$ 127,209	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	SEE ATTACHED SCHEDULE			\$ 61,770	\$ 3,576	\$ 3,576	\$	5-10	\$ 54,853	76
77										77
78										78
79										79
80	TOTALS			\$ 61,770	\$ 3,576	\$ 3,576	\$		\$ 54,853	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)	\$ 659,045	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,478	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,478	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)	\$ 433,005	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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

* 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 GROUP HOME #6 # 0037721 Report Period Beginning: 7/1/2013 Ending: 6/30/2014
 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>72</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>88</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	50	175		225
3	Classroom Wages (a)		3,982		3,982
4	Clinical Wages (b)		4,866		4,866
5	In-House Trainer Wages (c)	147	515		662
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 197	\$ 9,538	\$	\$ 9,735
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,735			

- (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	<u>7</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>2</u>
2. From other facilities (f)	
TOTAL TRAINED	9

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	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.

Facility Name & ID Number **GROUP HOME #6**# **0037721**Report Period Beginning: **7/1/2013**

Ending:

6/30/2014**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2014**

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,544,812		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)	\$ 1,544,812	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	434,402		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	219,643		16
17	Accumulated Depreciation (book methods)	(433,005)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 226,040	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,770,852	\$	25

		1 Operating	2 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
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	449,861		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)	\$ 449,861	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 449,861	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,320,991	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,770,852	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,272,040	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,272,040	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	48,951	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)	\$ 48,951	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)	\$ 1,320,991	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	\$ 670,216	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 670,216	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 670,216	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	110,639	31
32	Health Care	241,796	32
33	General Administration	175,217	33
B. Capital Expense			
34	Ownership	57,405	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	36,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 621,265	40
41	Income before Income Taxes (line 30 minus line 40)**	48,951	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 48,951	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 **GROUP HOME #6**

0037721

Report Period Beginning: **7/1/2013**

Ending:

6/30/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	16,011	16,975	191,412	11.28
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	386	422	4,798	11.37
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	195	275	2,442	8.88
16	Dishwashers				16
17	Maintenance Workers	1,417	1,551	17,917	11.55
18	Housekeepers	4,108	4,108	34,096	8.30
19	Laundry				19
20	Administrator	797	841	18,718	22.26
21	Assistant Administrator	104	104	3,441	33.09
22	Other Administrative	312	329	4,353	13.23
23	Office Manager				23
24	Clerical	1,867	2,038	28,667	14.07
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,080	2,264	31,172	13.77
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>SEE ATTACHED</u>	773	880	9,814	11.15
34	TOTAL (lines 1 - 33)	28,050	29,787	\$ 346,830 *	\$ 11.64

* 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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MARTHA WARFORD	EXECUTIVE DIRECTOR	0	\$ 5,214	Workers' Compensation Insurance	\$ 21,202	IDPH License Fee	\$	
VICKY PALMER-VOGT	ASSISTANT DIRECTOR	0	3,441	Unemployment Compensation Insurance	5,443	Advertising: Employee Recruitment	1,711	
BRENDA MILLER	FINANCIAL COORD.	0	2,531	FICA Taxes	26,456	Health Care Worker Background Check		
RACHEL LOLLIS	ADMINISTRATOR	0	13,503	Employee Health Insurance	26,164	(Indicate # of checks performed <u>4</u>)	780	
				Employee Meals		Patient Background Checks <u>2</u>	390	
				Illinois Municipal Retirement Fund (IMRF)*		DUES/SUBS/LICENSE FEES	796	
				PENSION	3,329	IHCA DUES	872	
				MISC EMPLOYEE BENEFITS	1,625			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 24,689	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,549		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
SCHOOL REIMBURSEMENT			\$ 9				Out-of-State Travel	\$
OUTSOURCING - IT/PAYROLL/TIMECLOCK			4,970					
MISCELLANEOUS			395				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 5,374				Seminar Expense	
C. Professional Services								
Vendor/Payee	Type	Amount						
SEE ENCLOSED WORKSHEET	LEGAL FEES	\$ 6,217						
SCHEFFEL BOYLE	ACCOUNTING & AUDITING	4,884						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 11,101	TOTAL			\$	

* Attach copy of IMRF notifications

**See instructions.

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number GROUP HOME #6

0037721

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSN (\$872)
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,208
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. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- 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? YES**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SCHEFFEL BOYLE
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.

GROUP HOME 6 (#0037721)
PAGES 3 & 4, SCHEDULE V RECLASSIFICATIONS
JUNE 30, 2014

BANK & BROKER FEES INCLUDED AS INTEREST	5,468	17
MORTGAGE INSURANCE PREMIUMS INCLUDED AS INTEREST	398	36
	(5,866)	32
CNA TRAINING INCLUDED AS NURSING	9,735	13
	(9,735)	10

GROUP HOME 6 (#0037721)
 VEHICLE DEPRECIATION - SCHEDULE XI., Section D.
 6/30/2014

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
1995 CHEVY VAN #7	\$ 1,260	\$-	\$-	\$ 1,260
SUPPLY LUMINA	791	-	-	791
MAINTENANCE #2 TRUCK	707	-	-	707
CAR # 4 REPAIRS	208	-	-	208
LIFT ON VAN # 10	256	-	-	256
MAINT #3 AND SPREADER	596	-	-	596
MAINT #1 DUMP TRUCK	1,200	-	-	1,200
VAN #6 FORD E350	751	-	-	751
MAINT #7 -BUCKET TRUCK	450	-	-	450
TRANSPORT-IDOT VAN #12	2,694	-	-	2,694
TRANS MAINT #4-F150	330	-	-	330
FORD FOCUS-CAR #1	545	-	-	545
TRANSP-15 PASS. VAN #1	1,709	-	-	1,709
IDOT VAN #15	2,218	-	-	2,218
IDOT VAN #16	2,218	-	-	2,218
TRANS. MAINT #6 -TRUCK	299	-	-	299
MAINT. #8 F350 TRUCK	1,329	-	-	1,329
TRANS. CAR # 3	76	-	-	76
Trans- Car # 6	197	-	-	197
BUS RENNOVATIONS	259	-	-	259
TRANS-VAN # 13	1,245	-	-	1,245
WHEELCHAIR VAN #5	1,825	-	-	1,825
IDOT BUS-VAN #17	4,384	-	-	4,384
Supply Van Mats	11	-	-	11
E-350 Van #18-15 pass.	1,362	-	-	1,362
E-350 Van #19-15 pass.	1,369	-	-	1,369
2005 GMC-VAN # 3-15 pass.	1,415	-	-	1,415
2005 GMC-VAN # 11-15 pass.	1,417	-	-	1,417
Truck for Maintenance	257	-	-	257
Wheelchair Straps for Van #17	32	-	-	32
2006 Chrysler Van #21	833	-	-	833
2006 Chrysler Van #10	867	-	-	867
Wheelchair Van # 20	1,697	-	-	1,697
IDOT VAN-#8	1,835	184	184	1,560
Maintenance Truck w/Snow Plow	1,670	-	-	1,670

Vans-Wheelchair Strap	121	-	-	121
Security Car	660	-	-	660
Transportation Van	1,804	-	-	1,804
Transportation Van	1,433	-	-	1,433
IDOT Van	1,628	-	-	1,628
Maintenance - Truck	1,703	170	170	1,703
Shoulder Harnesses	86	17	17	78
14 Passenger Van	2,950	590	590	2,655
IDOT Van	2,887	577	577	1,889
2010 Chrysler	1,574	315	315	1,102
Maintenance Truck	276	55	55	193
4X4 Chevy Truck	874	175	175	437
Chevy C1500 Silverado	1,120	224	224	560
2008 Mercury Mariner	861	172	172	431
Ford E250	2,045	409	409	1,023
Fleet Repairs	338	68	68	169
Dump Truck Repairs	35	7	7	11
Van Seat Repair	219	44	44	66
Van	2,844	569	569	853
	<u>\$ 61,770</u>	<u>\$ 3,576</u>	<u>\$ 3,576</u>	<u>\$ 54,853</u>

GROUP HOME 6 - #0037721
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2014

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
TRANSPORTATION	669	776	\$ 7,419	9.56
SAFETY & SECURITY	104	104	2,395	23.03
	<u>773</u>	<u>880</u>	<u>\$ 9,814</u>	