FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0036947

Facility Name: GROUP HOME #1

Address: 212 BACHMAN LANE (Number) GODFREY (City) 62035 (Zip Code)

County: MADISON

Telephone Number: (618) 466-0367 **Fax #** (618) 466-3652

HFS ID Number:

Date of Initial License for Current Owners: 07/19/1991

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: BRENDA MILLER **Telephone Number:** (618) 466-0367
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 7/1/2014 to 6/30/2015 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) MARTHA WARFORD
(Title) EXECUTIVE DIRECTOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) KIMBERLY S. LOY, PRINCIPAL
(Firm Name & Address) SCHEFFEL BOYLE, 106 W. COUNTY ROAD, JERSEYVILLE, IL 62052
(Telephone) (618) 498-6841 Fax # (618) 498-6842

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 GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 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		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 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					11
12	SC					12
13	DD 16 OR LESS	5,560	0		5,560	13
14	TOTALS	5,560			5,560	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.21%

D. How many bed-hold days during this year were paid by the Department?
242 (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 7/19/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/19/91 NO [ ]

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 N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,890	349		2,239		2,239		2,239			1
2	Food Purchase		33,224		33,224		33,224		33,224			2
3	Housekeeping	17,048	2,286		19,334		19,334		19,334			3
4	Laundry											4
5	Heat and Other Utilities			12,522	12,522		12,522		12,522			5
6	Maintenance	16,367	5,644	6,069	28,080		28,080		28,080			6
7	Other (specify):* SECURITY	2,371	118	4,563	7,052		7,052		7,052			7
8	**TOTAL General Services**	37,676	41,621	23,154	102,451		102,451		102,451			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	247,453	3,131		250,584	(6,712)	243,872		243,872			10
10a	Therapy											10a
11	Activities	4,427	1,054	188	5,669		5,669		5,669			11
12	Social Services			132	132		132		132			12
13	CNA Training					6,712	6,712		6,712			13
14	Program Transportation	6,546			6,546		6,546		6,546			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	258,426	4,185	320	262,931		262,931		262,931			16
	C. General Administration											
17	Administrative	23,159		4,324	27,483	5,675	33,158		33,158			17
18	Directors Fees											18
19	Professional Services			8,347	8,347		8,347		8,347			19
20	Dues, Fees, Subscriptions & Promotions			4,520	4,520		4,520		4,520			20
21	Clerical & General Office Expenses	28,094	3,174	8,072	39,340		39,340		39,340			21
22	Employee Benefits & Payroll Taxes			85,810	85,810		85,810		85,810			22
23	Inservice Training & Education			473	473		473		473			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			12,682	12,682		12,682		12,682			26
27	Other (specify):*											27
28	**TOTAL General Administration**	51,253	3,174	124,228	178,655	5,675	184,330		184,330			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	347,355	48,980	147,702	544,037	5,675	549,712		549,712			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 #1 #0036947 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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			23,885	23,885		23,885		23,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,915	23,915	(5,675)	18,240		18,240			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS.			2,187	2,187		2,187		2,187			36
37	**TOTAL Ownership**			49,987	49,987	(5,675)	44,312		44,312			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			40,896	40,896		40,896		40,896			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,896	40,896		40,896		40,896			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	347,355	48,980	238,585	634,920		634,920		634,920			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 GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 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

GROUP HOME #1

ID# 0036947

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

	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 GROUP HOME #1 **#** 0036947 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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 #1 **#** 0036947 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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 GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #5	GODFREY			
		GROUP HOME #6	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 [X] 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			$			$	$	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 #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	Brian Birnbaum	BOD						1
2	Hartley Carlton	BOD						2
3	Patricia Downey	BOD						3
4	William McMahon	BOD						4
5	Donald Perozzi	BOD						5
6	Roger Queen	BOD						6
7	Jeffrey Rosignol	BOD						7
8	Stephen Schmidt	BOD						8
9	Glenn Tiller	BOD						9
10	George Walker	BOD						10
11	Pamela Whisler	BOD						11
12	Keith Wright	BOD						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

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	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 #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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: BEVERLY FARM FOUNDATION & GROUP HOMES #2-#6
Street Address: GODFREY, IL 62035
City / State / Zip Code:
Phone Number: (618) 466-0367
Fax Number: (618) 466-3652

	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	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	$ 3,372,830	$	254	$ 85,810	1
2	17-3	SCHOOL REIMBURSEMENT	WAGES	10,000	8	133,710		293	3,914	2
3	17-1	ADMINISTRATIVE SALARIES	HOURS	2,080	8	223,482	223,482	104	11,174	3
4	17-3	ADMINISTRATIVE - OTHER	HOURS	2,080	8	102,595		8	410	4
5	21-1	PERSONNEL/ACCOUNTING	HOURS	2,080	8	561,880	561,880	104	28,094	5
6	6-1	MAINTENANCE STAFF	HOURS	2,080	8	327,337		104	16,367	6
7	7-3	SECURITY/SAFETY	HOURS	2,080	8	91,263		104	4,563	7
8	7-1	SAFETY MANAGER	HOURS	2,080	8	47,411	47,411	104	2,371	8
9	7-2	SECURITY SUPPLIES	HOURS	2,080	8	2,369		104	118	9
10	6-2	MAINTENANCE SUPPLIES	HOURS	2,080	8	112,883		104	5,644	10
11	21-2	OSHA REQUIREMENTS	HOURS	2,080	8	46,478		104	2,324	11
12	21-3	CONSULTANTS	HOURS	2,080	8	134,577		104	6,729	12
13	6-3	MAINTENANCE - OTHER	HOURS	2,080	8	78,809		104	3,940	13
14	26-3	INSURANCE	HOURS	2,080	8	253,648		104	12,682	14
15	19-3	LEGAL & ACCOUNTING	HOURS	2,080	8	197,958		88	8,347	15
16	14-1	TRANSPORTATION STAFF	HOURS	2,080	8	130,926	130,926	104	6,546	16
17	20-3	DUES/SUBS/ADVERTISING	HOURS	2,080	8	121,307		78	4,520	17
18	36-3	MORTGAGE INSURANCE	HOURS	2,080	8	43,743		104	2,187	18
19	32-3	INTEREST	HOURS	2,080	8	478,340		104	23,915	19
20	23-3	INSERVICE TRAINING	HOURS	2,080	8	10,872		90	473	20
21	11-1	ACTIVITIES STAFF	HOURS	2,080	8	88,540	88,540	104	4,427	21
22	11-2	ACTIVITIES SUPPLIES	HOURS	2,080	8	7,079		104	355	22
23	11-3	ACTIVITIES OTHER	HOURS	2,080	8	3,760		104	188	23
24										24
25	TOTALS					$ 6,571,797	$ 1,052,239		$ 235,098	25

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	GERSHMAN MORTGAGE		X	REFINANCE BONDS	$2,946.00	09/19/13	$ 460,755	$ 432,943	08/01/32	0.0417	$ 17,947	1
2	AMORTIZATION OF DEBT COSTS		X								293	2
3												3
4												4
5												5
	Working Capital											
6	LIBERTY BANK		X	WORKING CASH		04/21/15			04/21/16	0.0500		6
7												7
8												8
9	TOTAL Facility Related				$2,946.00		$ 460,755	$ 432,943			$ 18,240	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 460,755	$ 432,943			$ 18,240	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 2,187 Line # 36-3

*** 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 GROUP HOME #1 **#** 0036947 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:		
	2010	8
	2011	9
	2012	10
	2013	11
	2014	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROUP HOME #1 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0036947

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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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? [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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	10,000		$ 5,000	1
2					2
3	TOTALS	10,000		$ 5,000	3

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			1991	$ 380,640	$ 9,516	40	$ 9,516	$	$ 227,591	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1995	188		5			188	9
10	BUILDING IMPROVEMENTS			1999	3,738		VAR			3,738	10
11	BUILDING IMPROVEMENTS			2002	3,886		10			3,886	11
12	BUILDING IMPROVEMENTS			2003	3,726		10			3,726	12
13	BUILDING IMPROVEMENTS			2005	12,759	717	VAR	717		6,813	13
14	BUILDING IMPROVEMENTS			2006	272		5			272	14
15	FLOORING - HALLWAY, MED/NURSING ROOM, & STAFF BATHR			2014	4,067	407	10	407		610	15
16	SPRINKLER			2014	408	41	5	41		41	16
17	BUILDING IMPROVEMENTS			1996	55,926	1,389	VAR	1,389		26,036	17
18	BUILDING IMPROVEMENTS			1997	860		VAR			860	18
19	BUILDING IMPROVEMENTS			1998	941		15			941	19
20	BUILDING IMPROVEMENTS			1999	51	3	20	3		39	20
21	BUILDING IMPROVEMENTS			2000	26	1	20	1		20	21
22	BUILDING IMPROVEMENTS			2004	63	3	10	3		63	22
23	GBS-GYM FLOOR			2012	94	19	5	19		47	23
24	GUARD SHACK			2012	146	15	10	15		36	24
25	MAINT-BATHROOM			2013	192	39	5	39		96	25
26	MAINT-LIGHTING			2013	370	74	5	74		185	26
27	MAINT-SEWER REPAIRS			2013	1,062	106	10	106		266	27
28	MAINT-SPRINKLERS			2013	22	2	10	2		6	28
29	MAINT-WALL REPAIRS			2013	197	40	5	40		99	29
30	MAINT-COOLING			2013	62	12	5	12		31	30
31	NURSING-DOOR			2013	176	35	5	35		88	31
32	SECURITY CAMERAS			2013	704	141	5	141		352	32
33	MAINT-SLIDES FOR PUMP HOUSE			2014	539	54	10	54		81	33
34	MAINT-ASPHALT FOR ADMIN BUILDING			2014	311	57	5	57		57	34
35	MAINT-DOOR AT TRACTOR SHED			2014	36	5	5	5		5	35
36	ADMIN BUILDING-PARKING LOT			2015	210		5				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 #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	MAINT-SEWER MAIN REPAIR	2015	$ 682	$	10	$	$	$	37
38	MAINT-DOOR AND FRAME	2015	91		10				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)		$ 472,445	$ 12,676		$ 12,676	$	$ 276,173	70

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

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 51,480	$ 7,562	$ 7,562	$	5-10	$ 24,737	71
72	Current Year Purchases	9,254	400	400		5-10	400	72
73	Fully Depreciated Assets	71,679	144	144		5-10	71,679	73
74								74
75	TOTALS	$ 132,413	$ 8,106	$ 8,106	$		$ 96,816	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			$ 41,093	$ 3,103	$ 3,103	$	5-10	$ 37,276	76
77										77
78										78
79										79
80	TOTALS			$ 41,093	$ 3,103	$ 3,103	$		$ 37,276	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)	$ 650,951	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,885	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,885	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)	$ 410,265	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 GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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 #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 72

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 88

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		125		125
3	Classroom Wages (a)		2,844		2,844
4	Clinical Wages (b)		3,476		3,476
5	In-House Trainer Wages (c)		267		267
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 6,712	$	$ 6,712
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,712			

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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(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 GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number GROUP HOME #1 **#** 0036947 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2015 **(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)	1,459,154		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)**	$ 1,459,154	$	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	472,445		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	173,506		16
17	Accumulated Depreciation (book methods)	(410,265)		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)**	$ 240,686	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,699,840	$	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	432,943		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)**	$ 432,943	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 432,943	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,266,897	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,699,840	$	48

***(See instructions.)**

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,217,953	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,217,953	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	48,944	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)**	$ 48,944	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)**	$ 1,266,897	24	*

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

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 683,864	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 683,864	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)**	$ 683,864	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	102,451	31
32	Health Care	262,931	32
33	General Administration	178,655	33
	B. Capital Expense		
34	Ownership	49,987	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	40,896	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 634,920	40
41	**Income before Income Taxes (line 30 minus line 40)****	48,944	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 48,944	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 #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	18,846	19,390	216,285	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	339	380	4,427	11.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	200	200	1,890	9.45	15
16	Dishwashers					16
17	Maintenance Workers	1,161	1,303	16,367	12.56	17
18	Housekeepers	2,054	2,054	17,048	8.30	18
19	Laundry					19
20	Administrator	798	853	17,099	20.05	20
21	Assistant Administrator	104	104	3,498	33.63	21
22	Other Administrative	208	226	4,307	19.06	22
23	Office Manager					23
24	Clerical	2,197	2,423	26,349	10.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,080	2,112	31,168	14.76	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	742	812	8,917	10.98	33
34	TOTAL (lines 1 - 33)	28,729	29,857	$ 347,355 *	$ 11.63	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		$		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	5	132	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5	$ 132		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA WARFORD	EXECUTIVE DIRECTOR	0	$ 5,114
VICKY PALMER-VOGT	ASSISTANT DIRECTOR	0	3,498
BRENDA MILLER	FINANCIAL COORD.	0	2,562
RACHEL LOLLIS	ADMINISTRATOR	0	11,985
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 23,159

B. Administrative - Other

Description	Amount
SCHOOL REIMBURSEMENT	$ 22
OUTSOURCING - IT/PAYROLL/TIMECLOCK	3,892
MISCELLANEOUS	410
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 4,324

C. Professional Services

Vendor/Payee	Type	Amount
SEE ENCLOSED WORKSHEET	LEGAL FEES	$ 6,347
SCHEFFEL BOYLE	ACCOUNTING & AUDITING	2,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 8,347

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,380
Unemployment Compensation Insurance	3,760
FICA Taxes	26,516
Employee Health Insurance	30,269
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	3,513
MISC EMPLOYEE BENEFITS	1,372
TOTAL (agree to Schedule V, line 22, col.8)	$ 85,810

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,098
Health Care Worker Background Check	
(Indicate # of checks performed 4)	935
Patient Background Checks 1	234
DUES/SUBS/LICENSE FEES	352
IHCA DUES	901
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,520

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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			$		$	$	$	$	$	$	$	$	$
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 #1 # 0036947 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 ($901)**

(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. $ **40,896**
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? **98%**
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 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 1 (#0036947)
PAGES 3 & 4, SCHEDULE V RECLASSIFICATIONS
JUNE 30, 2015

BANK & BROKER FEES INCLUDED AS INTEREST	5,675	17
	(5,675)	32
CNA TRAINING INCLUDED AS NURSING	6,712	13
	(6,712)	10

GROUP HOME 1 (#0036947)
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.
JUNE 30, 2015

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
TRANS MAINT #4-F150	$ 330	$ -	$ -	$ 330
FORD FOCUS CAR #1	545	-	-	545
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
IDOT BUS-VAN #17	4,384	-	-	4,384
E-350 VAN #18-15 PASS.	1,362	-	-	1,362
E-350 VAN #19-15 PASS.	1,369	-	-	1,369
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	1,744
MAINTENANCE TRUCK W/SNOW PLOW	1,670	-	-	1,670
VANS-WHEELCHAIR STRAP	121	-	-	121
TRANSPORTATION VAN	1,804	-	-	1,804
TRANSPORTATION VAN	1,433	-	-	1,433
IDOT VAN	1,628	-	-	1,628
MAINTENANCE - TRUCK	1,703	-	-	1,703
SHOULDER HARNESSES	86	9	9	86
14 PASSENGER VAN (DISPOSED OF IN CY)	-	295	295	-
IDOT VAN	2,887	577	577	2,466
2010 CHRYSLER	1,574	315	315	1,416
MAINTENANCE TRUCK	276	55	55	249
4X4 CHEVY TRUCK	874	175	175	611
CHEVY C1500 SILVERADO	1,120	224	224	784
2008 MERCURY MARINER	861	172	172	603
FORD E250	2,045	409	409	1,431
FLEET REPAIRS	338	68	68	237
DUMP TRUCK REPAIRS	35	7	7	18
VAN SEAT REPAIR	219	44	44	110
VAN	2,844	569	569	1,422
	$ 41,093	$ 3,103	$ 3,103	$ 37,276

GROUP HOME 1 - #0036947
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2015

	1	2	3	4
SERVICE	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
TRANSPORTATION	574	644	$ 6,546	10.16
SAFETY & SECURITY	168	168	2,371	14.11
	742	812	$ 8,917	