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: 0014464

Facility Name: The Iroquois Resident Home

Address: 200 Fairman Avenue (Number) Watseka (City) 60970 (Zip Code)

County: Iroquois

Telephone Number: (815)432-5841 **Fax #** (815)432-7870

HFS ID Number:

Date of Initial License for Current Owners: 1958

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Jeffrey W. Petersen **Telephone Number:** 815-432-7720
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 10/1/14 to 9/30/15 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)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Brent Kochel, Manager
(Firm Name & Address) Kerber, Eck & Braeckel, LLP, 1116 West Main Street, Carbondale, IL 62901
(Telephone) (618)529-1040 Fax # (618)549-2311

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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	35	Skilled (SNF)	35	12,775	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	35	TOTALS	35	12,775	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	758	10,019	1,143	11,920	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	758	10,019	1,143	11,920	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.31%

D. How many bed-hold days during this year were paid by the Department?
0 (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 1958

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 44 and days of care provided 1,143

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/15 Fiscal Year: 9/30/15

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

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	4,542		19,076	23,618		23,618	404,621	428,239			1
2	Food Purchase							207,832	207,832			2
3	Housekeeping							42,292	42,292			3
4	Laundry			25,686	25,686		25,686	53,019	78,705			4
5	Heat and Other Utilities							32,120	32,120			5
6	Maintenance			4,247	4,247		4,247	129,854	134,101			6
7	Other (specify):*											7
8	TOTAL General Services	4,542		49,009	53,551		53,551	869,738	923,289			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	894,977	36,747	23,756	955,480		955,480	33,213	988,693			10
10a	Therapy			2,973	2,973		2,973		2,973			10a
11	Activities	34,661		5,515	40,176		40,176		40,176			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	929,638	36,747	32,244	998,629		998,629	33,213	1,031,842			16
	C. General Administration											
17	Administrative							95,876	95,876			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			3,383	3,383		3,383		3,383			20
21	Clerical & General Office Expenses	30,065	26,426	38,522	95,013		95,013	120,918	215,931			21
22	Employee Benefits & Payroll Taxes			69,393	69,393		69,393	176,075	245,468			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,429	1,429		1,429		1,429			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							14,389	14,389			26
27	Other (specify):*											27
28	TOTAL General Administration	30,065	26,426	112,727	169,218		169,218	407,258	576,476			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	964,245	63,173	193,980	1,221,398		1,221,398	1,310,209	2,531,607			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 The Iroquois Resident Home #0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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			86,927	86,927		86,927		86,927			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,269	7,269		7,269		7,269			35
36	Other (specify):*											36
37	**TOTAL Ownership**			94,196	94,196		94,196		94,196			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,410		9,410		9,410		9,410			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			24,090	24,090		24,090		24,090			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		9,410	24,090	33,500		33,500		33,500			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	964,245	72,583	312,266	1,349,094		1,349,094	1,310,209	2,659,303			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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	(78)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,310,287		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,310,287		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,310,209		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

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The Iroquois Resident Home

ID# 0014464

Report Period Beginning: 10/1/14

Ending: 9/30/15

	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 The Iroquois Resident Home **#** 0014464 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

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 The Iroquois Resident Home **#** 0014464 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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
Iroquois Memorial Hospital	100				Watseka, IL	Hospital
				Iroquois Home Care	Watseka, IL	DME retailer

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	Roger Dittrich	BOD						1
2	Steven Knapp	BOD						2
3	Dan Tincher	BOD						3
4	Mel Ward	BOD						4
5	Michael Tilstra	BOD						5
6	Rhonda Pence	BOD						6
7	Doug Geiger	BOD						7
8	Philip Zumwalt, MD	BOD						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

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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: Iroquois Memorial Hospital
Street Address: 200 E Fairman Ave
City / State / Zip Code: Watseka, IL 60970
Phone Number: (815) 432-5841
Fax Number: (815) 432-7870

	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	Employee Benefits	Gross Salaries	17,824,771		$ 2,793,780	$ 0	964,245	$ 151,132	1
2	21	Employee Benefits - Salary	Gross Salaries	17,824,771		121,118	121,118	964,245	6,552	2
3	21	Admitting	Gross Charges	69,881,733		624,105	343,185	2,238,875	19,995	3
4	10	Purchasing, Rec, & Stores	Costed Req's	2,863,497		195,546	110,549	63,173	4,314	4
5	21	Data Processing	Time Sepnt	652,864		801,371	324,991	59,107	72,552	5
6	21	Communications	# of Phones	422		257,341	34,589	11	6,708	6
7	21	Business Office	Gross Charges	69,881,733		474,081	293,144	2,238,875	15,189	7
8	17	Admin and General	Accum Cost	25,588,582		2,005,826	810,791	1,223,100	95,876	8
9	5	Heat	Square Feet	111,597		372,802	0	9,615	32,120	9
10	6	Maintenance	Square Feet	111,597		1,507,158	251,569	9,615	129,854	10
11	4	Laundry	Pounds	362,480		116,588	41,450	164,840	53,019	11
12	3	Housekeeping	Square Feet	108,618		477,763	296,208	9,615	42,292	12
13	1	Dietary	Meals	47,590		545,478	186,531	35,301	404,621	13
14	2	Food	Meals	47,590		280,183	0	35,301	207,832	14
15	22	Cafeteria	FTE's	26,045		228,588	168,226	2,842	24,943	15
16	10	Medical Records	Gross Charges	69,881,733		902,036	516,167	2,238,875	28,899	16
17	26	Property Insurance	Square Feet	135,564		41,831	0	9,615	2,967	17
18	26	Malpractice Insurance	Accum Cost	25,588,582		225,918	0	1,223,100	10,799	18
19	26	Cyber Insurance	Accum Cost	25,588,582		13,042	0	1,223,100	623	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 11,984,555	$ 3,498,518		$ 1,310,287	25

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number The Iroquois Resident Home **#** 0014464 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

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 The Iroquois Resident Home COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0014464

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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,615 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

Hospital (25 Beds), Home Health, Hospice, Rural Health Clinics, Clinics
Total other square feet - 128,093

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		9,615	1958	$ 57,278	1
2					2
3	TOTALS	9,615		$ 57,278	3

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	35		1958	1958	$ 296,212	$	40	$	$	$ 296,212	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFING			1976	27,273		20			27,273	9
10	CENTRAL A/C			1976	108,539		15			108,539	10
11	SPRINKLER SYSTEM			1977	20,560		20			20,560	11
12	5 DOOR SENSORS			1986	5,087		10			5,087	12
13	INSULATION WORK			1987	56,995		10			56,995	13
14	SEAL & WATERPROOF			1988	6,517		10			6,517	14
15	PAINT & WALLPAPER HALLS			1989	5,363		5			5,363	15
16	FLOORING			1989	6,243		10			6,243	16
17	ARCHITECT FEES			1990	500		15			500	17
18	LAND PREP RH GARDEN			1990	3,935		20			3,935	18
19	SHELVING			1990	619		20			619	19
20	SHELVING			1990	619		20			619	20
21	PAINTING, WALLPAPER, ETC.			1990	5,250		5			5,250	21
22	REMODELING			1990	6,684		10			6,684	22
23	RH GARDEN PATIO MASONRY WORK			1991	45,275		20			45,275	23
24	RH GARDEN IRRIGATION			1991	3,900		15			3,900	24
25	LANDSCAPING			1992	3,754		20			3,754	25
26	FENCING - GARDEN			1992	2,111		20			2,111	26
27	FENCING - CHAIN LENGTH			1992	2,595		20			2,595	27
28	PAVILLION			1992	6,540		20			6,540	28
29	GUTTERS			1992	1,200		15			1,200	29
30	LIGHTING			1992	7,000		15			7,000	30
31	PAINTING & PAPERING			1992	9,245		5			9,245	31
32	PARKING LOT NE			1995	58,302	1,458	20	1,458		58,302	32
33	RH GARDEN SIDEWALK			1995	2,480		15			2,480	33
34	8 X 8 PAIR ALUM DOORS			1995	3,093		10			3,093	34
35	PINE HAND RAILS			1995	383		10			383	35
36	LOT LITE POLE FEED			1996	1,081	54	20	54		1,053	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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	PARKING LOT	1997	$ 144,218	$ 7,211	20	$ 7,211	$	$ 133,402	37
38	LANDSCAPING - RH	1998	7,810		10			7,810	38
39	ARCH FEES	1998	19,585		15			19,585	39
40	BEDS	1998	57,478		12			57,478	40
41	CUBICAL CURTAINS (80)	1999	32,980		5			32,980	41
42	SIDE WALKS WEST & SOUTH	1999	2,305		15			2,305	42
43	REMODELING RH	1999	17,488		5			17,488	43
44	#2529 HOM DELTA LAU FAUCETS (14)	1999	2,085	104	20	104		1,718	44
45	REMODELING RESTROOMS	1999	69,743	3,487	20	3,487		57,538	45
46	TILE	1999	22,658		5			22,658	46
47	GIFT HAND RAIL 1.5 ROUND	1999	1,708	56	15	56		1,708	47
48	RH REMODELING	1999	27,360	912	15	912		27,360	48
49	SIDEWALKS M & K CENTER	1999	833	28	15	28		833	49
50	NURSE CALL SYSTEM	1999	13,747		10			13,747	50
51	FLOOR TILE	2000	19,932	664	15	664		19,932	51
52	RH REMODELING	2000	1,360		5			1,360	52
53	ASBESTOS PROGRAM	2000	6,212		5			6,212	53
54	LIGHTS & WIRING	2000	5,885	198	15	198		5,885	54
55	ARCH FEES	2000	580		5			580	55
56	RH REMODELING	2000	45,000	1,500	15	1,500		45,000	56
57	OAK CABINETS	2000	6,160	204	15	204		6,160	57
58	RH REMODELING & PAINT	2001	356		5			356	58
59	RH REMODELING - COUNTER TOPS (16)	2001	1,794	90	20	90		1,303	59
60	HEADS IN REST ROOMS (4)	2001	735	37	20	37		534	60
61	FAUCETS (3)	2001	517	26	20	26		375	61
62	CERAMIC TILE & FLOOR FIVE ROOMS	2001	4,650	232	20	232		3,371	62
63	REMODELING - ELECTRICAL (8 ROOMS)	2004	2,524	168	15	168		2,438	63
64	RH - REMODELING ELECTRICAL	2001	43,796	2,920	15	2,920		42,338	64
65	CABINETS, 8 DRAWER OAK	2002	2,710	181	15	181		2,441	65
66	FAN COIL UNIT	2002	11,469	765	15	765		10,324	66
67	REMODELING RH	2002	81,294	5,420	15	5,420		73,166	67
68	ARCH FEES	2003	13,259		5			13,259	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,365,586	$ 25,715		$ 25,715	$	$ 1,328,971	70

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

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	
1	Totals from Page 12A, Carried Forward		$ 1,365,586	$ 25,715		$ 25,715	$	$ 1,328,971	1
2	DOOR & FRAME	2003	6,665	444	15	444		5,553	2
3	RH-IDPH	2003	7,027		5			7,027	3
4	RH-IDPH	2003	8,376		5			8,376	4
5	LEVEL & LOCK ANDERSON LOCK	2004	4,965		10			4,965	5
6	SCONCES & HANGING PENDANT BALLACOR	2004	5,875	392	15	392		4,505	6
7	PAINTING (DEXTER DECORATING)	2004	13,848		5			13,848	7
8	PLUMBING (JENTER INC)	2004	32,604	1,630	20	1,630		18,747	8
9	ENTIRE WHITE CABINETRY & VINIONEER	2004	5,663	378	15	378		4,342	9
10	FLOORING - KINDON'S	2004	14,315	954	15	954		10,974	10
11	PENNER PT CARE - CASCADE WHIRLPOOL SYST	2004	13,695		10			13,695	11
12	REMODELING RH	2004	45,388	3,026	15	3,026		34,798	12
13	CERAMIC TIME	2004	28,590	1,430	20	1,430		16,440	13
14	CARPET SHAW	2004	17,968		5			17,968	14
15	FIXTURES	2004	13,017		10			13,017	15
16	MISC REMODELING - RH	2004	7,104		10			7,104	16
17	SMOKE DETECTOR - IDPH - SIMPLEX	2004	4,201		10			4,201	17
18	NURSES STATION	2004	23,000		10			23,000	18
19	CHART RACK CABINET	2004	2,317	116	20	116		1,332	19
20	PIPE RH CHILLED WATER LOOP	2005	8,450	338	25	338		3,549	20
21	WANTER GUARD SYSTEM	2006	13,663	1,366	10	1,366		12,980	21
22	CONCRETE SIDEWALK & HAND RAILS	2009	12,760	851	15	851		5,530	22
23	STEEL SMOKE BARRIER - RH	2012	8,694	580	15	580		1,739	23
24	RH CANOPY/AWNING	2013	6,710	447	15	447		1,118	24
25	INSTALL RH HEATING/VENTILATION & AC UPGRADE	2013	310,794	20,720	15	20,720		56,979	25
26	AMERICAN HEALTHTECH SYSTEM	2014	40,282	13,427	3	13,427		13,427	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,021,557	$ 71,814		$ 71,814	$	$ 1,634,185	34

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

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 22,140	$ 1,686	$ 1,686	$		$ 20,472	71
72	Current Year Purchases	40,282	13,427	13,427		3	13,427	72
73	Fully Depreciated Assets	72,463						73
74								74
75	TOTALS	$ 134,885	$ 15,113	$ 15,113	$		$ 33,899	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 2,213,720	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,927	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,927	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)	$ 1,668,084	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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

(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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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 The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/15 (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	$	$ 598,043	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	433,498	4,633,980	3
4	Supply Inventory (priced at)		1,087,834	4
5	Short-Term Investments		406,885	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		1,493,936	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 433,498	$ 8,220,678	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,354,229	12
13	Land	57,278	291,325	13
14	Buildings, at Historical Cost	2,021,557	25,352,580	14
15	Leasehold Improvements, at Historical Cost		483,750	15
16	Equipment, at Historical Cost	134,885	15,546,819	16
17	Accumulated Depreciation (book methods)	(1,668,084)	(29,091,311)	17
18	Deferred Charges		68,894	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Perpetual Trust**		8,300,177	22
23	Other(specify): **CIP**		41,605	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 545,636	$ 22,348,068	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 979,134	$ 30,568,746	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 2,329,934	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		883,098	29
30	Accrued Salaries Payable		3,082,324	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)**	$	$ 6,295,356	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,009,816	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Asset Retirement Obligation**		305,795	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,315,611	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 10,610,967	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 979,134	$ 19,957,779	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 979,134	$ 30,568,746	48

*(See instructions.)

Facility Name & ID Number The Iroquois Resident Home **#** 0014464 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,240,544	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,240,544	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(261,410)	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)**	$ (261,410)	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)**	$ 979,134	24 *

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

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 2,238,875	1
2	Discounts and Allowances for all Levels	(1,151,191)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,087,684	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)**	$ 1,087,684	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	53,551	31
32	Health Care	998,629	32
33	General Administration	169,218	33
	B. Capital Expense		
34	Ownership	94,196	34
	C. Ancillary Expense		
35	Special Cost Centers	33,500	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,349,094	40
41	**Income before Income Taxes (line 30 minus line 40)****	(261,410)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (261,410)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 56,797	44
45	Private Pay - Net Inpatient Revenue	860,078	45
46	Medicare - Net Inpatient Revenue	169,140	46
47	Other-(specify) Commercial	1,670	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,087,685	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.**

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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	2,080	2,080	$ 70,397	$ 33.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,016	7,016	187,878	26.78	3
4	Licensed Practical Nurses	12,323	12,323	251,522	20.41	4
5	CNAs & Orderlies	32,161	32,161	384,580	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,805	2,805	34,314	12.23	9
10	Activity Assistants					10
11	Social Service Workers	112	112	1,347	12.03	11
12	Dietician	44	44	4,513	102.57	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,120	2,120	29,694	14.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	58,661	58,661	$ 964,245 *	$ 16.44	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	0	5,215	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	48	2,973	10a, 3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	48	$ 8,188		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	69,393
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Medicare cost report expenses (allocated	
benefits)	176,075
TOTAL (agree to Schedule V, line 22, col.8)	$ 245,468

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	$ 2,322
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IL Health Care Assn	202
Newspaper/Magazine/Online Book	459
Misc Dues	400
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,383

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,429
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,429

**See instructions.

Facility Name & ID Number The Iroquois Resident Home # 0014464 Report Period Beginning: 10/1/14 Ending: 9/30/15

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		$		$	$	$	$	$	$	$	$	$

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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. **Illinois Health Care Assn $**

(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 $78**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **35**

(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? **15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,410** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(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. $ **24,090**
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. $ **24,943** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **Offset on Medicare Cost**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Kerber, Eck & Braeckel, LLP**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.