

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

<p>I. IDPH License ID Number: <u>8004552</u></p> <p>Facility Name: <u>Crawford Memorial Hosp LTC</u></p> <p>Address: <u>1000 North Allen St</u> <u>Robinson</u> <u>62454</u> Number City Zip Code</p> <p>County: <u>Crawford</u></p> <p>Telephone Number: <u>(618)546-2568</u> Fax # <u>(618)546-2682</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/29/2012</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%"> <input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: _____ Telephone Number: (_____) Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p align="center"> I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>5/1/2015</u> to <u>4/30/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. </p> <p align="center"> Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. </p> <table style="width:100%"> <tr> <td style="width:25%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:25%;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Brent Kochel</u> <u>Manager</u> (Firm Name & Address) <u>Kerber, Eck & Braeckel, LLP</u> <u>1116 West Main Street, Carbondale, IL 62901</u> (Telephone) <u>(618)529-1040</u> Fax # <u>(618)549-2311</u></td> </tr> </table> <p align="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Brent Kochel</u> <u>Manager</u> (Firm Name & Address) <u>Kerber, Eck & Braeckel, LLP</u> <u>1116 West Main Street, Carbondale, IL 62901</u> (Telephone) <u>(618)529-1040</u> Fax # <u>(618)549-2311</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Brent Kochel</u> <u>Manager</u> (Firm Name & Address) <u>Kerber, Eck & Braeckel, LLP</u> <u>1116 West Main Street, Carbondale, IL 62901</u> (Telephone) <u>(618)529-1040</u> Fax # <u>(618)549-2311</u>							

Facility Name & ID Number Crawford Memorial Hosp LTC

8004552 Report Period Beginning: 5/1/2015 Ending: 4/30/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	35	Skilled (SNF)	35	12,810	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	12,810	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		170	7,296	7,466	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		170	7,296	7,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.28%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 3/29/2012

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 38 and days of care provided 1,152

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 4/30/16 Fiscal Year: 4/30/16

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

Facility Name & ID Number Crawford Memorial Hosp LTC # 8004552 Report Period Beginning: 5/1/2015 Ending: 4/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary						486,182	486,182			1
2	Food Purchase										2
3	Housekeeping						66,662	66,662			3
4	Laundry						87,979	87,979			4
5	Heat and Other Utilities						226,656	226,656			5
6	Maintenance		7,414		7,414		7,414	7,414			6
7	Other (specify):*										7
8	TOTAL General Services		7,414		7,414		7,414	867,479	874,893		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	645,796	41,430		687,226		687,226	687,226			10
10a	Therapy										10a
11	Activities	31,118		4,389	35,507		35,507	35,507			11
12	Social Services	33,193			33,193		33,193	578	33,771		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	710,107	41,430	4,389	755,926		755,926	578	756,504		16
	C. General Administration										
17	Administrative	83,748			83,748		83,748	335,001	418,749		17
18	Directors Fees										18
19	Professional Services			5,837	5,837		5,837		5,837		19
20	Dues, Fees, Subscriptions & Promotions			1,790	1,790		1,790		1,790		20
21	Clerical & General Office Expenses	24,777		970	25,747		25,747	17,128	42,875		21
22	Employee Benefits & Payroll Taxes			56,251	56,251		56,251	187,905	244,156		22
23	Inservice Training & Education			1,865	1,865		1,865		1,865		23
24	Travel and Seminar			4,901	4,901		4,901		4,901		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							21,262	21,262		26
27	Other (specify):* Flower Baskets		870		870		870		870		27
28	TOTAL General Administration	108,525	870	71,614	181,009		181,009	561,296	742,305		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	818,632	49,714	76,003	944,349		944,349	1,429,353	2,373,702		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

Crawford Memorial Hosp LTC

#8004552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							167,892	167,892			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			6,152	6,152		6,152		6,152			35
36	Other (specify):* Small Equipment			14,225	14,225		14,225		14,225			36
37	TOTAL Ownership			20,377	20,377		20,377	167,892	188,269			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			68,758	68,758		68,758		68,758			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			68,758	68,758		68,758		68,758			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	818,632	49,714	165,138	1,033,484		1,033,484	1,597,245	2,630,729			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 Crawford Memorial Hosp LTC

8004552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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

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

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	
							52

Crawford Memorial Hosp LTC

ID# 8004552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

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 Crawford Memorial Hosp LTC# 8004552 Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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 Crawford Memorial Hosp LTC# 8004552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	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

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
Crawford Memorial Hospital	100					

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

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

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

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

Facility Name & ID Number

Crawford Memorial Hosp LTC

8004552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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								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

Facility Name & ID Number Crawford Memorial Hosp LTC # 8004552 Report Period Beginning: 5/1/2015 Ending: 4/30/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Crawford Memorial Hosp LTC

8004552

Report Period Beginning:

5/1/2015

Ending: 1/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Crawford Memorial Hospital

Street Address

1000 Noth Allen Street

City / State / Zip Code

Robinson, IL 62454

Phone Number

(618)546-2568

Fax Number

(618)546-2682

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Gross Salaries	18,916,887	\$ 3,638,383	\$	819,210	\$ 157,563	1
2	21	Employee Benefits - Salary	Gross Salaries	18,916,887	196,531	196,531	819,210	8,511	2
3	21	Admitting	Gross Revenue	76,685,822	515,725	375,181	0	0	3
4	10	Purchasing Rec & Stores	Costed Req's	928	287,205	155,220	19	5,880	4
5	21	Data Processing	Time Spent	10,000	1,242,538	236,295	0	0	5
6	21	Nonpatient Telephones	# of phones	411	38,304	0	28	2,610	6
7	32	Cashiering/Accounts Rec	Gross Revenue	76,685,822	1,570,751	299,779	0	0	7
8	17	Admin and General	Accum Cost	36,734,236	3,415,813	580,262	1,376,645	128,010	8
9	5	Operation of Plant	Square Feet	107,182	2,231,624	455,359	10,886	226,656	9
10	4	Laundry	Pounds	197,913	320,176	85,630	54,383	87,979	10
11	3	Housekeeping	Square Feet	111,020	679,847	328,691	10,886	66,662	11
12	1	Dietary	Meals	44,373	786,287	498,769	27,437	486,182	12
13	22	Cafeteria	FTE's	267	405,066	0	20	30,342	13
14	17	Nursing Administration	Nursing Hours	247,568	1,004,881	621,092	42,620	172,995	14
15	26	Property Insurance	Square Feet	107,182	104,422	0	10,886	10,606	15
16	26	Malpractice Insurance	Accum Cost	36,734,236	322,981	0	1,193,205	10,491	16
17	26	Cyber Insurance	Accum Cost	36,734,236	5,075	0	1,193,205	165	17
18	17	Social Service	Time Spent	100	99,989	59,030	34	33,996	18
19	30	Movable Equipment	Dollar Value	990,384	818,350		10,742	8,876	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 17,683,948	\$ 3,891,839		\$ 1,437,524	25

Facility Name & ID Number

Crawford Memorial Hosp LTC

8004552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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 2016 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:	2011	8	
	2012	9	
	2013	10	
	2014	11	
	2015	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015 \$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Crawford Memorial Hosp LTC COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 8004552

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 2015 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 2015.

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

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Crawford Memorial Hosp LTC

8004552 Report Period Beginning:

5/1/2015 Ending:

4/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,886 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).

Total other square feet - 146,553

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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Row 1: Land, 10,886, 2012, \$, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 10,886, (blank), \$, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	35	2011		\$ 2,036,956	\$ 101,848	20	\$ 101,848	\$	\$ 526,214	4
5		2012		825,557	41,278	20	41,278		168,551	5
6		2011		53,488	2,674	20	2,674		12,481	6
7										7
8										8
Improvement Type**										
9	Floor plans, drywall, roll base, etc		2002	10,877	725	15	725		10,213	9
10	Zink's plumbing-mat for hetrs		2004	15,098		10			15,098	10
11	Commercial doos and Hardware		2004	1,962	98	20	98		1,129	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

*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 Crawford Memorial Hosp LTC

8004552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	2,943,938	\$	146,623	\$	146,623	\$	733,686	70

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

Facility Name & ID Number Crawford Memorial Hosp LTC

8004552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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	\$ 292,508	\$ 24,227	\$ 24,227	\$		\$ 171,818	71
72	Current Year Purchases	6,266	104	104			104	72
73	Fully Depreciated Assets	22,494					22,494	73
74								74
75	TOTALS	\$ 321,268	\$ 24,331	\$ 24,331	\$		\$ 194,416	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)	\$ 3,265,206	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,954	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,954	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)	\$ 928,102	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 Crawford Memorial Hosp LTC

8004552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 6,152 Description: Wound Care Equipment

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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

	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 prescripts							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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **4/30/2016**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 8,407,664	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	415,408	6,443,928	3
4	Supply Inventory (priced at)		1,066,154	4
5	Short-Term Investments			5
6	Prepaid Insurance		509,413	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		267,272	8
9	Other(specify): Assets whose use is limited		953,217	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 415,408	\$ 17,647,648	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		2,608,580	11
12	Long-Term Investments		14,587,160	12
13	Land		340,645	13
14	Buildings, at Historical Cost	2,916,001	47,313,415	14
15	Leasehold Improvements, at Historical Cost	27,937	1,146,066	15
16	Equipment, at Historical Cost	321,268	12,532,915	16
17	Accumulated Depreciation (book methods)	(928,102)	(29,899,112)	17
18	Deferred Charges		2,738,814	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): Construction In Progress		2,828,025	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,337,104	\$ 54,196,508	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,752,512	\$ 71,844,156	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 1,114,555	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		2,556,437	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		10,266	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Third party reimbursement program		819,000	36
37	Other current liabilities		547,169	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 5,047,427	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		14,064,241	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation		2,738,814	42
	Other Long-Term Liabilities(specify):			
43	Deferred Revenue		34,206	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,837,261	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 21,884,688	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,752,512	\$ 49,959,468	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,752,512	\$ 71,844,156	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,763,007	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,763,007	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	989,505	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)	\$ 989,505	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,752,512	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Crawford Memorial Hosp LTC

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,041,141	1
2	Discounts and Allowances for all Levels	(18,152)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,022,989	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)	\$ 2,022,989	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	7,414	31
32	Health Care	755,926	32
33	General Administration	181,009	33
B. Capital Expense			
34	Ownership	20,377	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	68,758	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,033,484	40
41	Income before Income Taxes (line 30 minus line 40)**	989,505	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 989,505	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue	1,676,305	45
46	Medicare - Net Inpatient Revenue	346,684	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,022,989	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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Ending:

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,279	1,279	\$ 53,804	\$ 42.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,945	5,945	191,256	32.17	3
4	Licensed Practical Nurses	3,120	3,120	62,832	20.14	4
5	CNAs & Orderlies	20,486	20,486	314,179	15.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,801	1,801	31,118	17.28	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					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	1,586	1,586	83,748	52.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,766	1,766	24,777	14.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,115	1,115	33,193	29.77	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Director</u>	776	776	23,725	30.57	33
34	TOTAL (lines 1 - 33)	37,874	37,874	\$ 818,632 *	\$ 21.61	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sandra Burtron	Administrator	0	\$ 83,748	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	56,251	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance		Misc Dues	1,690	
				Employee Meals		INHAA Dues	100	
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,748					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
			\$				Non-allowable advertising ()	
							Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount		Line #	Amount	Amount	
Verify	Background Check		\$ 1,024			\$	Out-of-State Travel	
Health Service Consultants	Consulting		3,426				\$	
Lakeside Upholstery	Upholster Services		301					
GHS Physician Services	Consulting		180				In-State Travel	
St. Mary's Hospital	Outside Services		586					
Rex Allen	Outside Services		320				Seminar Expense	
							4,901	
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 5,837	TOTAL			\$	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 4,901	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Crawford Memorial Hosp LTC

8004552

Report Period Beginning:

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Ending:

4/30/2016

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. INHAA \$100
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 48
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,105 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. \$ 68,758
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. \$ 30,342 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