

		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.

**I. IDPH License ID Number:** 0031955

**Facility Name:** Davies Square

**Address:** 1817 Crescent Drive Pekin 61554  
Number City Zip Code

**County:** Tazewell

**Telephone Number:** (309)347-2609 Fax # (309)347-5796

**HFS ID Number:** \_\_\_\_\_

**Date of Initial License for Current Owners:** 03/06/87

**Type of Ownership:**

<input checked="" type="checkbox"/>	<b>VOLUNTARY, NON-PROFIT</b>	<input type="checkbox"/>	<b>PROPRIETARY</b>	<input type="checkbox"/>	<b>GOVERNMENTAL</b>
<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
<b>IRS Exemption Code</b>	<u>501 (c) 3</u>	<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____
		<input type="checkbox"/>	"Sub-S" Corp.	<input type="checkbox"/>	_____
		<input type="checkbox"/>	Limited Liability Co.	<input type="checkbox"/>	_____
		<input type="checkbox"/>	Trust	<input type="checkbox"/>	_____
		<input type="checkbox"/>	Other	<input type="checkbox"/>	_____

**In the event there are further questions about this report, please contact:**  
Name: Ron Wilson Telephone Number: (309) 343-1550  
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 10/1/15 to 9/30/16 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) <u>Pat Devine</u>	
	(Title) <u>Executive Director</u>	

Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____
	(Print Name and Title) <u>Larry Templin Partner</u>	
	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u>	
	(Telephone) <u>(630) 361-2868</u> Fax # ( ) _____	

MAIL TO: BUREAU OF HEALTH FINANCE  
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
201 S. Grand Avenue East  
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Davies Square

# 0031955 Report Period Beginning: 10/1/15 Ending: 9/30/16

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,512			5,512	13
14	TOTALS	5,512			5,512	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.13%**

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

49 (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  Non-allowable costs have been eliminated in Schedule V, Column 7

**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 03/06/87

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

YES  Date 06/07/90 NO

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

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 9/30/2016 Fiscal Year: 9/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Davies Square # 0031955 Report Period Beginning: 10/1/15 Ending: 9/30/16

**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
	<b>A. General Services</b>										
1	Dietary	37,783	4,942	870	43,595		43,595		43,595		1
2	Food Purchase		55,373		55,373		55,373		55,373		2
3	Housekeeping	19,480	4,931		24,411		24,411		24,411		3
4	Laundry		5,460		5,460		5,460		5,460		4
5	Heat and Other Utilities			15,652	15,652		15,652		15,652		5
6	Maintenance	14,678	5,525	9,934	30,137		30,137	148	30,285		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	71,941	76,231	26,456	174,628		174,628	148	174,776		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	225,336	10,276	7,527	243,139		243,139		243,139		10
10a	Therapy			333	333		333		333		10a
11	Activities		2,233	872	3,105		3,105		3,105		11
12	Social Services										12
13	CNA Training	16,803			16,803		16,803		16,803		13
14	Program Transportation			9,771	9,771		9,771		9,771		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	242,139	12,509	18,503	273,151		273,151		273,151		16
	<b>C. General Administration</b>										
17	Administrative										17
18	Directors Fees							1,036	1,036		18
19	Professional Services			62,405	62,405		62,405	1,901	64,306		19
20	Dues, Fees, Subscriptions & Promotions			3,890	3,890		3,890	49	3,939		20
21	Clerical & General Office Expenses	7,452	2,752	4,637	14,841		14,841	2	14,843		21
22	Employee Benefits & Payroll Taxes			64,009	64,009		64,009	4	64,013		22
23	Inservice Training & Education			4,655	4,655		4,655	3	4,658		23
24	Travel and Seminar			290	290		290		290		24
25	Other Admin. Staff Transportation			2,017	2,017		2,017		2,017		25
26	Insurance-Prop.Liab.Malpractice			5,165	5,165		5,165	842	6,007		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	7,452	2,752	147,068	157,272		157,272	3,837	161,109		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	321,532	91,492	192,027	605,051		605,051	3,985	609,036		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Davies Square

#0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

## 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	
	<b>D. Ownership</b>											
30	Depreciation			22,344	22,344		22,344	(419)	21,925			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											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			22,344	22,344		22,344	(419)	21,925			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			37,160	37,160		37,160		37,160			42
43	Other (specify):* <b>Disallowed Costs</b>			1,961	1,961		1,961	(1,961)				43
44	<b>TOTAL Special Cost Centers</b>			39,121	39,121		39,121	(1,961)	37,160			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	321,532	91,492	253,492	666,516		666,516	1,605	668,121			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Davies Square**

# **0031955**

Report Period Beginning:

**10/1/15**

Ending:

**9/30/16**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(419)	30		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	(1,961)	43		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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,380)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	3,985		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 3,985		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,605		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Davies Square

ID# 0031955

Report Period Beginning: 10/1/15

Ending: 9/30/16

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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
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	148	0	0	0	0	0	0	0	0	0	148	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	148	0	0	0	0	0	0	0	0	0	148	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	1,036	0	0	0	0	0	0	0	0	0	1,036	18
19	Professional Services	0	1,901	0	0	0	0	0	0	0	0	0	1,901	19
20	Fees, Subscriptions & Promotions	0	49	0	0	0	0	0	0	0	0	0	49	20
21	Clerical & General Office Expenses	0	2	0	0	0	0	0	0	0	0	0	2	21
22	Employee Benefits & Payroll Taxes	0	4	0	0	0	0	0	0	0	0	0	4	22
23	Inservice Training & Education	0	3	0	0	0	0	0	0	0	0	0	3	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	842	0	0	0	0	0	0	0	0	0	842	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	3,837	0	0	0	0	0	0	0	0	0	3,837	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	0	3,985	0	0	0	0	0	0	0	0	0	3,985	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(419)	0	0	0	0	0	0	0	0	0	0	(419)	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	<b>TOTAL Ownership</b>	<b>(419)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(419)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(1,961)	0	0	0	0	0	0	0	0	0	0	(1,961)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,961)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,961)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(2,380)</b>	<b>3,985</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,605</b>	<b>45</b>



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
None	N/A	Community Living Options, Inc. (CLO)		See Page 6 Supplemental		
		Unlimited Development, Inc. (CLO is sole member)				
		See Page 6 Supplemental for specific homes				

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	6 Maintenance	\$	Community Living Options, Inc.	100.00%	\$ 148	\$ 148	1	
2	V	18 Director Fees		Community Living Options, Inc.	100.00%	1,036	1,036	2	
3	V	19 Professional Fees		Community Living Options, Inc.	100.00%	1,901	1,901	3	
4	V	20 Dues, Licenses and Subs		Community Living Options, Inc.	100.00%	49	49	4	
5	V	21 General Admin Expense		Community Living Options, Inc.	100.00%	2	2	5	
6	V	22 Employee Benefits		Community Living Options, Inc.	100.00%	4	4	6	
7	V	23 Inservice Training & Education		Community Living Options, Inc.	100.00%	3	3	7	
8	V	26 Property/ Liability Insurance		Community Living Options, Inc.	100.00%	842	842	8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 3,985	\$ *	3,985	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

## 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	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

## 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	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court-CILA	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryville				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Care Center of Abingdon	Abingdon				20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCorn	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Marti	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Davies Square # 0031955 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	See Attached Schedule 7A								\$ 1,036	L18, C7	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	\$ 1,036		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending: 9/30/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Frances House, Inc.

Street Address

285 S. Farnham

City / State / Zip Code

Galesburg, IL 61401

Phone Number

( 309) 343-1550

Fax Number

( 309) 343-2857

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

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	6	Maintenance	Bed Days Available	193,248	35	\$ 4,884	\$ 5,856	\$ 148	1
2	18	Director Fees	Bed Days Available	193,248	35	34,193	5,856	1,036	2
3	19	Professional Fees	Bed Days Available	193,248	35	62,727	5,856	1,901	3
4	20	Dues, Licenses and Subs	Bed Days Available	193,248	35	1,609	5,856	49	4
5	21	General Admin Expense	Bed Days Available	193,248	35	56	5,856	2	5
6	22	Employee Benefits	Bed Days Available	193,248	35	130	5,856	4	6
7	23	Inservice Training & Education	Bed Days Available	193,248	35	90	5,856	3	7
8	26	Property/ Liability Insurance	Bed Days Available	193,248	35	27,790	5,856	842	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	TOTALS					\$ 131,479	\$	\$ 3,985	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

**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		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$								
2	N/A																	
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>					\$	\$			\$								
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$								
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$								

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.)

SEE ACCOUNTANTS' PREPARATION REPORT

\*\* 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.)	2015	\$	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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	N/A	8
	2012	N/A	9
	2013	N/A	10
	2014	N/A	11
	2015	N/A	12

<b>FOR BHF USE ONLY</b>			
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

**The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.**

**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.**

SEE ACCOUNTANTS' PREPARATION REPORT



**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Davies Square COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0031955

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. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**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 Davies Square

# 0031955 Report Period Beginning:

10/1/15 Ending:

9/30/16

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 3,900 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>33,541</u>	<u>1990</u>	<u>\$ 22,692</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>33,541</b>		<b>\$ 22,692</b>	<b>3</b>

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Davies Square

# 0031955

Report Period Beginning:

10/1/15

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**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1990	1986	\$ 412,308	\$ 14,163	30	\$ 13,744	\$ (419)	\$ 361,925	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Garage, Parking Lot, Sidewalks, Landscaping		1986	30,000		15			30,000	9
10	Alarm System		1997	1,900		10			1,900	10
11	Roof, Roof Repair, and Men's Shower		2001	9,250	263	10-20yrs	263		8,613	11
12	Women's Shower		2002	1,980	99	20	99		1,444	12
13	Carpeting, Furnace		2005	18,377	806	5-15yrs	806		15,016	13
14	Concrete		2006	2,580	172	15	172		1,792	14
15	New Central Air Unit		2008	3,200		5			3,200	15
16	Shower		2009	3,806	381	10	381		2,918	16
17	Cabinets		2009	7,261	484	15	484		3,630	17
18	Bathroom Remodel-Vanity/Tubs/Showers/Sinks/Mirrors		2011	12,601	1,050	12	1,050		5,863	18
19	Bathroom Remodel-Toilet/Walls/Floor/Dry Wall/Drain/Tub		2011	28,968	2,414	12	2,414		13,076	19
20	Handrails and mounting brackets		2012	2,605	174	15	174		825	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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ <b>534,836</b>		\$ <b>20,006</b>	\$ <b>19,587</b>	\$ <b>(419)</b>	\$ <b>450,202</b>	<b>70</b>

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number **Davies Square**

# **0031955**

Report Period Beginning:

**10/1/15**

Ending:

**9/30/16**

**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	\$ 65,772	\$ 1,819	\$ 1,819	\$	3-15 yrs	\$ 50,353	71
72	Current Year Purchases	5,969	519	519		5-10 yrs	519	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 71,741	\$ 2,338	\$ 2,338	\$		\$ 50,872	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	N/A						\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 629,269	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,344	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,925	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (419)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 501,074	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A- Facility Owned

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	<b>TOTAL</b>				\$			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 \_\_\_\_\_.

N/A

N/A

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 0 Description: N/A

(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	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>138</u></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)		16,803		16,803
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 16,803	\$	\$ 16,803
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	16,803		

**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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>8</b>

- (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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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	<b>TOTAL</b>			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT



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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	51,320	51,320	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	87	87	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,301,055	2,301,055	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,352,462	\$ 2,352,462	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	22,692	13
14	Buildings, at Historical Cost	547,528	534,836	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	71,741	71,741	16
17	Accumulated Depreciation (book methods)	(512,201)	(501,074)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 117,068	\$ 128,195	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,469,530	\$ 2,480,657	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 2,700	\$ 2,700	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,393	9,393	30
31	Accrued Taxes Payable (excluding real estate taxes)	356	356	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
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 12,449	\$ 12,449	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 12,449	\$ 12,449	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,457,081	\$ 2,468,208	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,469,530	\$ 2,480,657	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,486,803</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	(1)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,486,802</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(29,721)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(29,721)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,457,081</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ <b>619,552</b>	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ <b>619,552</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	<b>16,803</b>	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ <b>16,803</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	<b>440</b>	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ <b>440</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ <b>636,795</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	<b>174,628</b>	31
32	Health Care	<b>273,151</b>	32
33	General Administration	<b>157,272</b>	33
<b>B. Capital Expense</b>			
34	Ownership	<b>22,344</b>	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	<b>1,961</b>	35
36	Provider Participation Fee	<b>37,160</b>	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ <b>666,516</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(29,721)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ <b>(29,721)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ <b>619,552</b>	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ <b>619,552</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Davies Square

# 0031955

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	2,072	39,737	18.40	4
5	CNAs & Orderlies	16,892	174,032	9.73	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				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	2,921	37,783	12.57	15
16	Dishwashers				16
17	Maintenance Workers	1,024	14,678	12.65	17
18	Housekeepers	1,950	19,480	9.99	18
19	Laundry				19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	401	7,452	17.25	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,603	28,370	16.42	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)	26,863	321,532 *	11.35	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	Monthly	\$ 870	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	95	L10, C3	38
39	Pharmacist Consultant	Monthly	1,202	L10, C3	39
40	Physical Therapy Consultant	Monthly	56	L10A, C3	40
41	Occupational Therapy Consultant	Monthly	277	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental</u>	Monthly	4,990	L10, C3	46
47	<u>Psychological Consultant</u>	Monthly	1,240	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,730		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Davies Square**

# **0031955**

Report Period Beginning: **10/1/15**

Ending: **9/30/16**

**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		
Courtney Buhlig	Administrator	None	\$	Workers' Compensation Insurance	\$ 7,271	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	154		
				FICA Taxes	24,667	Health Care Worker Background Check	1,197		
				Employee Health Insurance	26,411	(Indicate # of checks performed <u>48</u> )			
				Employee Meals	1,648	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*					
				401k	1,792	Subscriptions	1,617		
				Other Employee Benefits	2,220	IHCA Dues	912		
						Other Licenses & Fees	10		
						Indirect costs	49		
TOTAL (agree to Schedule V, line 17, col. 1)			\$			Less: Public Relations Expense	( )		
(List each licensed administrator separately.)						Non-allowable advertising	( )		
						Yellow page advertising	( )		
<b>B. Administrative - Other</b>									
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 64,013		
N/A			\$				TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 3,939		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>				<b>G. Schedule of Travel and Seminar**</b>	
(Attach a copy of any management service agreement)				Description				Amount	
<b>C. Professional Services</b>									
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description		
RFMS, Inc.	Administrative Services	\$ 33,990		N/A			Out-of-State Travel		
LTC Support Services, LLC	Support Services	25,560					\$		
RSM US LLP	Accounting Services	1,853							
Templin Healthcare Accounting	Accounting Services	1,002					In-State Travel		
							Seminar Expense		
							290		
							Entertainment Expense		
							( )		
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL				\$	
(For legal fee disclosure, see page 39 of instructions)			62,405					TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 290	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name & ID Number Davies Square# 0031955

Report Period Beginning:

10/1/15Ending: 9/30/16**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. 912 IHCA
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,671 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 37,160  
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. \$ 1,648 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: RSM US 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

**SEE ACCOUNTANTS' PREPARATION REPORT**