

		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:** 0037713

**Facility Name:** GROUP HOME #5

**Address:** 308 BACHMAN GODFREY 62035  
Number City Zip Code

**County:** MADISON

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

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

**Date of Initial License for Current Owners:** 02/21/1992

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<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"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
Name: BRENDA MILLER Telephone Number: (618) 466-0367  
Email Address: \_\_\_\_\_

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2015 to 6/30/2016 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>MARTHA WARFORD</u>	
	(Title) <u>EXECUTIVE DIRECTOR</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>KIMBERLY S. LOY</u> <u>PRINCIPAL</u>	
	(Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>106 W. COUNTY ROAD, JERSEYVILLE, IL 62052</u>	
	(Telephone) <u>(618) 498-6841</u> Fax # <u>(618) 498-6842</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number GROUP HOME #5

# 0037713 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

**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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 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	5,302	4		5,306	13
14	TOTALS	5,302	4		5,306	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.61%

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

259 (Do not include bed-hold days in Section B.)

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

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 02/21/1992

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

YES  Date 02/21/1992 NO

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

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number      GROUP HOME #5      # 0037713      Report Period Beginning: 7/1/2015      Ending: 6/30/2016

**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
	<b>A. General Services</b>										
1	Dietary	39,625	138		39,763		39,763		39,763		1
2	Food Purchase		28,604		28,604		28,604		28,604		2
3	Housekeeping	17,048	2,224		19,272		19,272		19,272		3
4	Laundry										4
5	Heat and Other Utilities			11,955	11,955		11,955		11,955		5
6	Maintenance	16,981	8,221	5,555	30,757		30,757		30,757		6
7	Other (specify):* SECURITY	2,369	30	4,761	7,160		7,160		7,160		7
8	<b>TOTAL General Services</b>	<b>76,023</b>	<b>39,217</b>	<b>22,271</b>	<b>137,511</b>		<b>137,511</b>		<b>137,511</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	170,450	4,085		174,535	(7,992)	166,543		166,543		10
10a	Therapy										10a
11	Activities	3,681	659	167	4,507		4,507		4,507		11
12	Social Services										12
13	CNA Training					7,992	7,992		7,992		13
14	Program Transportation	5,525			5,525		5,525		5,525		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>179,656</b>	<b>4,744</b>	<b>167</b>	<b>184,567</b>		<b>184,567</b>		<b>184,567</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	19,773		5,459	25,232	5,716	30,948		30,948		17
18	Directors Fees										18
19	Professional Services			4,880	4,880		4,880		4,880		19
20	Dues, Fees, Subscriptions & Promotions			4,446	4,446		4,446		4,446		20
21	Clerical & General Office Expenses	30,585	2,754	8,040	41,379		41,379		41,379		21
22	Employee Benefits & Payroll Taxes			106,407	106,407		106,407		106,407		22
23	Inservice Training & Education										23
24	Travel and Seminar			479	479		479		479		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			10,965	10,965		10,965		10,965		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>50,358</b>	<b>2,754</b>	<b>140,676</b>	<b>193,788</b>	<b>5,716</b>	<b>199,504</b>		<b>199,504</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>306,037</b>	<b>46,715</b>	<b>163,114</b>	<b>515,866</b>	<b>5,716</b>	<b>521,582</b>		<b>521,582</b>		<b>29</b>

\*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 &amp; ID Number

GROUP HOME #5

#0037713

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

## 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	
	<b>D. Ownership</b>											
30	Depreciation			24,786	24,786		24,786		24,786			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,699	23,699	(5,716)	17,983		17,983			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS.			2,523	2,523		2,523		2,523			36
37	<b>TOTAL Ownership</b>			51,008	51,008	(5,716)	45,292		45,292			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			41,024	41,024		41,024		41,024			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			41,024	41,024		41,024		41,024			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	306,037	46,715	255,146	607,898		607,898		607,898			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<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				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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	
						52	

GROUP HOME #5

ID# 0037713

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROUP HOME #5# 0037713 Report Period Beginning:

7/1/2015

Ending:

6/30/2016

## 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	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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	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	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	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROUP HOME #5 # 0037713 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</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>0</b>	<b>0</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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</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>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<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>0</b>	<b>0</b>	<b>45</b>



Facility Name & ID Number

GROUP HOME #5

# 0037713

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BEVERLY FARM FOUNDATION	GODFREY			
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #6	GODFREY			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  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.

**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	Patricia Downey	BOD						1
2	Leonard Aldridge	BOD						2
3	Barry Allswang	BOD						3
4	Terry Becker	BOD						4
5	Brian Birnbaum	BOD						5
6	Emily Friend	BOD						6
7	Nicholas Lynn	BOD						7
8	Jeffrey Rosignol	BOD						8
9	Stephen Schmidt	BOD						9
10	David Swain	BOD						10
11	Glenn Tiller	BOD						11
12	George Walker	BOD						12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	<b>BOARD OF DIRECTORS</b>	<b>BOD</b>	<b>BOD</b>	<b>0.00</b>	<b>NONE</b>	<b>7</b>	<b>0.00</b>		<b>\$ 0</b>	<b>N/A</b>	<b>1</b>
2	<b>(SEE PAGE 6)</b>										<b>2</b>
3											<b>3</b>
4											<b>4</b>
5											<b>5</b>
6											<b>6</b>
7											<b>7</b>
8											<b>8</b>
9											<b>9</b>
10											<b>10</b>
11											<b>11</b>
12											<b>12</b>
13								<b>TOTAL</b>	<b>\$</b>		<b>13</b>

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

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

Facility Name & ID Number GROUP HOME #5 # 0037713 Report Period Beginning: 7/1/2015 Ending: 5/30/2016

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 BEVERLY FARM FOUNDATION & GROUP HOMES #1, #2, #3, #4, & #6  
 Street Address GODFREY, IL 62035  
 City / State / Zip Code ( 618) 466-0367  
 Phone Number ( 618) 466-3652  
 Fax Number

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	\$ 4,448,163	\$ 239	\$ 106,407	1
2	17-3	OUTSOURCING-IT/PAYROLL/	WAGES	10,000	8	139,307	261	3,636	2
3	17-1	ADMINISTRATIVE SALARIES	HOURS	2,080	8	227,040	227,040	11,352	3
4	17-3	ADMINISTRATIVE-OTHER	HOURS	2,080	8	123,253	31	1,823	4
5	21-1	PERSONNEL/ACCOUNTING	HOURS	2,080	8	611,704	611,704	30,585	5
6	6-1	MAINTENANCE STAFF	HOURS	2,080	8	339,616	339,616	16,981	6
7	7-3	SECURITY/SAFETY	HOURS	2,080	8	95,220	104	4,761	7
8	7-1	SAFETY MANAGER	HOURS	2,080	8	47,384	47,384	2,369	8
9	7-2	SECURITY SUPPLIES	HOURS	2,080	8	608	104	30	9
10	6-2	MAINTENANCE SUPPLIES	HOURS	2,080	8	164,426	104	8,221	10
11	21-2	OSHA REQUIREMENTS	HOURS	2,080	8	46,360	104	2,318	11
12	21-3	CONSULTANTS	HOURS	2,080	8	134,239	104	6,712	12
13	6-3	MAINTENANCE-OTHER	HOURS	2,080	8	83,632	104	4,182	13
14	26-3	INSURANCE	HOURS	2,080	8	219,309	104	10,965	14
15	19-3	LEGAL & ACCOUNTING	HOURS	2,080	8	145,641	70	4,880	15
16	14-1	TRANSPORTATION STAFF	HOURS	2,080	8	110,497	110,497	5,525	16
17	20-3	DUES/SUBS/ADVERTISING	HOURS	2,080	8	118,361	78	4,446	17
18	36-3	MORTGAGE INSURANCE	HOURS	2,080	8	50,466	104	2,523	18
19	32-3	INTEREST	HOURS	2,080	8	473,978	104	23,699	19
20	24-3	TRAVEL & SEMINAR	HOURS	2,080	8	12,275	81	479	20
21	11-1	ACTIVITIES STAFF	HOURS	2,080	8	73,614	73,614	3,681	21
22	11-2	ACTIVITIES SUPPLIES	HOURS	2,080	8	5,800	104	290	22
23	11-3	ACTIVITIES OTHER	HOURS	2,080	8	3,342	104	167	23
24									24
25	TOTALS					\$ 7,674,235	\$ 1,409,855	\$ 256,032	25

Facility Name & ID Number

GROUP HOME #5

# 0037713

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

**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	2	3	4	5	6		7	8	9	10
					Original	Balance				
Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
<b>A. Directly Facility Related</b>										
<b>Long-Term</b>										
1		X	REFINANCE BONDS	\$2,746.00	09/19/13	\$ 460,755	\$ 415,305	08/01/32	0.0417	\$ 17,689
2		X	AMORTIZATION OF DEBT COSTS							294
3										
4										
5										
<b>Working Capital</b>										
6		X	WORKING CAPITAL		04/21/16			04/21/17	0.0500	
7										
8										
9			<b>TOTAL Facility Related</b>	\$2,746.00		\$ 460,755	\$ 415,305			\$ 17,983
<b>B. Non-Facility Related*</b>										
10										
11										
12										
13										
14			<b>TOTAL Non-Facility Related</b>			\$	\$			\$
15			<b>TOTALS (line 9+line14)</b>			\$ 460,755	\$ 415,305			\$ 17,983

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 2,523      Line # 36-3

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

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

**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. <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	8	
	2012	9	
	2013	10	
	2014	11	
	2015	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

**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 GROUP HOME #5 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0037713

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 GROUP HOME #5

# 0037713 Report Period Beginning:

7/1/2015 Ending:

6/30/2016

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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



XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16			1992	\$ 317,200	\$ 7,930	40	\$ 7,930	\$	\$ 191,642	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<u>BUILDING IMPROVEMENTS</u>		1995	188		5			188	9
10		<u>BUILDING IMPROVEMENTS</u>		1999	1,211		10			1,211	10
11		<u>BUILDING IMPROVEMENTS</u>		2000	5,476		5			5,476	11
12		<u>BUILDING IMPROVEMENTS</u>		2002	6,785		10			6,785	12
13		<u>BUILDING IMPROVEMENTS</u>		2005	1,801	90	10	90		1,801	13
14		<u>BUILDING IMPROVEMENTS</u>		2007	874		5			874	14
15		<u>BUILDING IMPROVEMENTS</u>		2008	793		5			793	15
16		<u>COUNTER TOPS</u>		2013	1,986	199	10	199		695	16
17		<u>PAINTING</u>		2013	4,715	943	5	943		3,300	17
18		<u>SPRINKLER</u>		2013	4,199	420	10	420		1,470	18
19		<u>FLOORING-NORTHEAST GIRLS TV ROOM, MED/NURSING</u>		2014	3,908	390	10	390		977	19
20		<u>BUILDING IMPROVEMENTS-ALLOCATED</u>		1996	55,926	1,389	VAR	1,389		27,426	20
21		<u>BUILDING IMPROVEMENTS-ALLOCATED</u>		1997	860		VAR			860	21
22		<u>BUILDING IMPROVEMENTS-ALLOCATED</u>		1998	941		15			941	22
23		<u>BUILDING IMPROVEMENTS-ALLOCATED</u>		1999	52	3	20	3		42	23
24		<u>BUILDING IMPROVEMENTS-ALLOCATED</u>		2000	27	1	20	1		21	24
25		<u>BUILDING IMPROVEMENTS-ALLOCATED</u>		2004	63		10			63	25
26		<u>BUILDING IMPROVEMENTS-ALLOCATED</u>		2012	239	33	VAR	33		117	26
27		<u>MAINT-BATHROOM-ALLOCATED</u>		2013	192	39	5	39		135	27
28		<u>MAINT-LIGHTING-ALLOCATED</u>		2013	370	74	5	74		259	28
29		<u>MAINT-SEWER REPAIRS-ALLOCATED</u>		2013	1,062	106	10	106		372	29
30		<u>MAINT-SPRINKLERS-ALLOCATED</u>		2013	22	2	10	2		8	30
31		<u>MAINT-WALL REPAIRS-ALLOCATED</u>		2013	197	40	5	40		138	31
32		<u>MAINT-COOLING-ALLOCATED</u>		2013	62	12	5	12		43	32
33		<u>NURSING-DOOR-ALLOCATED</u>		2013	176	35	5	35		123	33
34		<u>SECURITY CAMERAS-ALLOCATED</u>		2013	704	141	5	141		493	34
35		<u>MAINT-SLIDES FOR PUMP HOUSE-ALLOCATED</u>		2014	539	54	10	54		135	35
36		<u>MAINT-ASPHALT FOR ADMIN BUILDING-ALLOCATED</u>		2014	310	63	5	63		119	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

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	MAINT-DOOR AT TRACTOR SHED-ALLOCATED	2014	\$ 36	\$ 8	5	\$ 8	\$	\$ 12	37
38	ADMIN BUILDING-PARKING LOT-ALLOCATED	2015	210	42	5	42		42	38
39	MAINT-SEWER MAIN REPAIR-ALLOCATED	2015	682	68	10	68		68	39
40	MAINT-DOOR AND FRAME-ALLOCATED	2015	91	9	10	9		9	40
41	MAINT-FLOOR COVERINGS-ALLOCATED	2015	43	9	5	9		9	41
42	MAINT-REPLACED SIDEWALKS-ALLOCATED	2015	231	31	5	31		31	42
43	MAINT-REPLACED SPRINKLERS-ALLOCATED	2015	154	30	5	30		30	43
44	MAINT-NEW 42X64 BUILDING-ALLOCATED	2016	2,418	20	20	20		20	44
45	MAINT-AIR CONDITIONER UNITS-ALLOCATED	2016	1,432	24	10	24		24	45
46	MAINT-CEILING TILE-ALLOCATED	2016	128	4	5	4		4	46
47	MAINT-CLOSET LOCKS-ALLOCATED	2016	125	4	5	4		4	47
48	MAINT-CORNER GUARDS-ALLOCATED	2016	95		5				48
49	MAINT-DOOR LOCKSETS-ALLOCATED	2016	348	9	10	9		9	49
50	MAINT-NEW FIRE ALARM PANEL-ALLOCATED	2016	268	18	5	18		18	50
51	MAINT-PAINTING-ALLOCATED	2016	301		5				51
52	MAINT-REPLACE FIRE ALARMS-ALLOCATED	2016	824		10				52
53	MAINT-REPLACED SEWER LINES-ALLOCATED	2016	148	6	10	6		6	53
54	MAINT-REPLACED WATER HEATER-ALLOCATED	2016	427	11	10	11		11	54
55	ROOF REPLACEMENT	2016	17,440		20				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)		\$ 436,279	\$ 12,257		\$ 12,257	\$	\$ 246,804	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 54,725	\$ 8,623	\$ 8,623	\$	5-10	\$ 23,104	71
72	Current Year Purchases	7,308	91	91		5-10	91	72
73	Fully Depreciated Assets	89,769	1,581	1,581		5-10	89,769	73
74								74
75	TOTALS	\$ 151,802	\$ 10,295	\$ 10,295	\$		\$ 112,964	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SEE ATTACHED SCHEDULE			\$ 41,093	\$ 2,234	\$ 2,234	\$	5-10	\$ 39,507	76
77										77
78										78
79										79
80	TOTALS			\$ 41,093	\$ 2,234	\$ 2,234	\$		\$ 39,507	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)	\$ 634,174	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,786	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,786	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)	\$ 399,275	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

Facility Name & ID Number

GROUP HOME #5

# 0037713

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

**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	<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 \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<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.

**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>72</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>88</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	50	125		175
3	Classroom Wages (a)	506	3,160		3,666
4	Clinical Wages (b)		3,476		3,476
5	In-House Trainer Wages (c)	337	338		675
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$ 893	\$ 7,099	\$	\$ 7,992
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 7,992			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>7</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.

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	4					
					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 **6/30/2016**

(last day of reporting year)

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 )	1,602,264		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,602,264	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	436,279		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	192,895		16
17	Accumulated Depreciation (book methods)	(399,275)		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>	\$ 234,899	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,837,163	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	415,305		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>	\$ 415,305	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 415,305	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,421,858	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,837,163	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,361,694</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<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>1,361,694</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>60,164</b>	<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>60,164</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>1,421,858</b>	<b>24</b> *

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



Facility Name &amp; ID Number GROUP HOME #5

# 0037713

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

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

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 668,062	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 668,062	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		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>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</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>	\$ 668,062	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	137,511	31
32	Health Care	184,567	32
33	General Administration	199,504	33
<b>B. Capital Expense</b>			
34	Ownership	45,292	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	41,024	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 607,898	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	60,164	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 60,164	43

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

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **GROUP HOME #5**

# **0037713**

Report Period Beginning:

**7/1/2015**

Ending:

**6/30/2016**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	252	3,681	13.24	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	2,681	39,625	10.93	15
16	Dishwashers				16
17	Maintenance Workers	1,703	16,981	9.35	17
18	Housekeepers	2,054	17,048	8.30	18
19	Laundry				19
20	Administrator	451	13,356	28.66	20
21	Assistant Administrator	104	3,580	34.42	21
22	Other Administrative	208	4,172	19.77	22
23	Office Manager				23
24	Clerical	2,372	29,250	11.75	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,080	32,127	15.04	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	11,319	138,323	11.36	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)	565	7,894	12.55	33
34	TOTAL (lines 1 - 33)	23,789	306,037 *	11.78	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	
MARTHA WARFORD	EXECUTIVE DIRECTOR	0	\$ 4,935	Workers' Compensation Insurance	\$ 18,035	IDPH License Fee	\$	
VICKY PALMER-VOGT	ASSISTANT DIRECTOR	0	3,580	Unemployment Compensation Insurance	2,724	Advertising: Employee Recruitment	1,741	
BRENDA MILLER	FINANCIAL COORD.	0	2,837	FICA Taxes	23,077	Health Care Worker Background Check		
RACHEL LOLLIS	ADMINISTRATOR	0	8,421	Employee Health Insurance	58,948	(Indicate # of checks performed <u>3</u> )	754	
				Employee Meals		Patient Background Checks <u>1</u>	252	
				Illinois Municipal Retirement Fund (IMRF)*		DUES/SUBS/LICENSE FEES	751	
				PENSION	2,203	IHCA DUES	948	
				MISC EMPLOYEE BENEFITS	1,420			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 19,773			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
OUTSOURCING- IT/PAYROLL/TIMECLOCK			\$ 3,636					
MISCELLANEOUS			1,823					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 5,459	TOTAL (agree to Schedule V, line 22, col.8)	\$ 106,407	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,446	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SEE ENCLOSED WORKSHEET	LEGAL FEES		\$ 2,380				Out-of-State Travel	\$
SCHEFFEL BOYLE	ACCOUNTING & AUDITING		2,500					
							In-State Travel	
							Seminar Expense	
							MEETINGS/SEMINARS/HOTEL	479
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 4,880	TOTAL			(agree to Sch. V, line 24, col. 8)	\$ 479

\* Attach copy of IMRF notifications

\*\*See instructions.

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL HEALTH CARE ASSN (\$948)
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 41,024  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? 92%  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? YES  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: SCHEFFEL BOYLE
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees

GROUP HOME 5 (#0037713)  
PAGES 3 & 4, SCHEDULE V RECLASSIFICATIONS  
JUNE 30, 2016

BANK & BROKER FEES INCLUDED AS INTEREST	5,716	17
	(5,716)	32
CNA TRAINING INCLUDED AS NURSING	7,992	13
	(7,992)	10

GROUP HOME 5 (#0037713)  
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.  
JUNE 30, 2016

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
TRANS MAINT #4-F150	\$ 330	\$ -	\$ -	\$ 330
FORD FOCUS CAR #1	545	-	-	545
IDOT VAN #15	2,218	-	-	2,218
IDOT VAN #16	2,218	-	-	2,218
TRANS. MAINT. #6 -TRUCK	299	-	-	299
MAINT. #8 F350 TRUCK	1,329	-	-	1,329
IDOT BUS-VAN #17	4,384	-	-	4,384
E-350 VAN #18-15 PASS.	1,362	-	-	1,362
E-350 VAN #19-15 PASS.	1,369	-	-	1,369
TRUCK FOR MAINTENANCE	257	-	-	257
WHEELCHAIR STRAPS FOR VAN #17	32	-	-	32
2006 CHRYSLER VAN #21	833	-	-	833
2006 CHRYSLER VAN #10	867	-	-	867
WHEELCHAIR VAN # 20	1,697	-	-	1,697
IDOT VAN-#8	1,835	92	92	1,835
MAINTENANCE TRUCK W/SNOW PLOW	1,670	-	-	1,670
VANS-WHEELCHAIR STRAP	121	-	-	121
TRANSPORTATION VAN	1,804	-	-	1,804
TRANSPORTATION VAN	1,433	-	-	1,433
IDOT VAN	1,628	-	-	1,628
MAINTENANCE - TRUCK	1,703	-	-	1,703
SHOULDER HARNESSSES	86	-	-	86
IDOT VAN	2,887	289	289	2,755
2010 CHRYSLER	1,574	157	157	1,574
MAINTENANCE TRUCK	276	28	28	276
4X4 CHEVY TRUCK	874	175	175	786
CHEVY C1500 SILVERADO	1,120	224	224	1,008
2008 MERCURY MARINER	861	172	172	775
FORD E250	2,045	409	409	1,840
FLEET REPAIRS	338	68	68	304
DUMP TRUCK REPAIRS	35	7	7	25
VAN SEAT REPAIR	219	44	44	154
VAN	2,844	569	569	1,990
	<u>\$ 41,093</u>	<u>\$ 2,234</u>	<u>\$ 2,234</u>	<u>\$ 39,507</u>

GROUP HOME 5 - #0037713  
PAGE 20, SCHEDULE XVIII, LINE 33  
JUNE 30, 2016

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
TRANSPORTATION	461	525	\$ 5,525	10.52
SAFETY & SECURITY	104	104	2,369	22.78
	565	629	\$ 7,894	