FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0035246

Facility Name: Henderson County Ret Center

Address: 604 Oakwood Drive (Number) Stronghurst (City) 61480 (Zip Code)

County: Henderson

Telephone Number: 309-924-1123 **Fax #** 309-924-1926

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501 C3	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: James G. Hull, C.P.A. **Telephone Number:** 217-228-1950
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 01/01/16 to 12/31/16 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) James G. Hull, C.P.A. / Owner/Vice Pres
(Firm Name & Address) WDM Computer Services, Inc. / 1900 Harrison St, Quincy, IL 62301
(Telephone) 217-228-1950 Fax # 217-222-6053

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 Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,647	6,826	1,691	13,164	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,647	6,826	1,691	13,164	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.95%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 06/28/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/28/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 1,691

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	148,477	12,091	5,429	165,997		165,997		165,997			1
2	Food Purchase		104,727		104,727		104,727	(13,296)	91,431			2
3	Housekeeping	54,100	7,129	23	61,252		61,252		61,252			3
4	Laundry	25,059	1,797		26,856		26,856		26,856			4
5	Heat and Other Utilities			64,007	64,007		64,007		64,007			5
6	Maintenance	61,531	6,491	46,055	114,077		114,077	(10,000)	104,077			6
7	Other (specify):*											7
8	TOTAL General Services	289,167	132,235	115,514	536,916		536,916	(23,296)	513,620			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	825,297	79,985	26,371	931,653		931,653	(112)	931,541			10
10a	Therapy		1,215	265,430	266,645	(125)	266,520		266,520			10a
11	Activities	39,748	7,496	1,500	48,744		48,744		48,744			11
12	Social Services	36,817	1,618	1,125	39,560	125	39,685		39,685			12
13	CNA Training			134	134		134		134			13
14	Program Transportation	45	11,689		11,734		11,734		11,734			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	901,907	102,003	305,060	1,308,970		1,308,970	(112)	1,308,858			16
	C. General Administration											
17	Administrative	81,448			81,448		81,448		81,448			17
18	Directors Fees											18
19	Professional Services			22,891	22,891		22,891		22,891			19
20	Dues, Fees, Subscriptions & Promotions			18,759	18,759		18,759	(5,737)	13,022			20
21	Clerical & General Office Expenses	31,310	9,090	27,539	67,939		67,939	(2,834)	65,105			21
22	Employee Benefits & Payroll Taxes			197,638	197,638		197,638		197,638			22
23	Inservice Training & Education			2,570	2,570		2,570		2,570			23
24	Travel and Seminar			2,560	2,560		2,560		2,560			24
25	Other Admin. Staff Transportation		1,299		1,299		1,299		1,299			25
26	Insurance-Prop.Liab.Malpractice			47,585	47,585		47,585		47,585			26
27	Other (specify):*			2,589	2,589		2,589	(471)	2,118			27
28	TOTAL General Administration	112,758	10,389	322,131	445,278		445,278	(9,042)	436,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,303,832	244,627	742,705	2,291,164		2,291,164	(32,450)	2,258,714			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Henderson County Ret Center #0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			144,204	144,204		144,204	(12,074)	132,130			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,996	34,996		34,996	(9,977)	25,019			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,067	3,067		3,067		3,067			35
36	Other (specify):*											36
37	**TOTAL Ownership**			182,267	182,267		182,267	(22,051)	160,216			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,620		47,620		47,620		47,620			39
40	Barber and Beauty Shops		115	4,429	4,544		4,544		4,544			40
41	Coffee and Gift Shops		4,803		4,803		4,803		4,803			41
42	Provider Participation Fee			102,575	102,575		102,575		102,575			42
43	Other (specify):*			15,217	15,217		15,217	(15,216)	1			43
44	**TOTAL Special Cost Centers**		52,538	122,221	174,759		174,759	(15,216)	159,543			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,303,832	297,165	1,047,193	2,648,190		2,648,190	(69,717)	2,578,473			45

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

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,034)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(112)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(78)	30		9
10	Interest and Other Investment Income	(9,977)	32		10
11	Discounts, Allowances, Rebates & Refunds	(262)	2		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	(471)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,216)	43		24
25	Fund Raising, Advertising and Promotional	(5,737)	20		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	(24,829)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,717)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (69,717)		37

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

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

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

Henderson County Ret Center

ID# 0035246

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lease Buy-out	$ (11,996)	30	1
2	Allocation of Wages to SLF-Clerical	(2,833)	21	2
3	Allocation of Wages to SLF-Maintenance	(10,000)	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,829)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,296)	0	0	0	0	0	0	0	0	0	0	(13,296)	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	(10,000)	0	0	0	0	0	0	0	0	0	0	(10,000)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(23,296)	0	0	0	0	0	0	0	0	0	0	(23,296)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(112)	0	0	0	0	0	0	0	0	0	0	(112)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(112)	0	0	0	0	0	0	0	0	0	0	(112)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,737)	0	0	0	0	0	0	0	0	0	0	(5,737)	20
21	Clerical & General Office Expenses	(2,834)	0	0	0	0	0	0	0	0	0	0	(2,834)	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):*	(471)	0	0	0	0	0	0	0	0	0	0	(471)	27
28	**TOTAL General Administration**	(9,042)	0	0	0	0	0	0	0	0	0	0	(9,042)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,450)	0	0	0	0	0	0	0	0	0	0	(32,450)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Henderson County Ret Center # 0035246 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(12,074)	0	0	0	0	0	0	0	0	0	0	(12,074)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,977)	0	0	0	0	0	0	0	0	0	0	(9,977)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,051)	0	0	0	0	0	0	0	0	0	0	(22,051)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,216)	0	0	0	0	0	0	0	0	0	0	(15,216)	43
44	**TOTAL Special Cost Centers**	(15,216)	0	0	0	0	0	0	0	0	0	0	(15,216)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(69,717)	0	0	0	0	0	0	0	0	0	0	(69,717)	45

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Security Savings		X	Mortgage	$8,312.05	10/22/08	$ 849,849	$ 579,797	08/01/2039	5.8750	$ 34,996	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$8,312.05		$ 849,849	$ 579,797			$ 34,996	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 849,849	$ 579,797			$ 34,996	15

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

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

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

Facility Name & ID Number Henderson County Ret Center **#** 0035246 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Henderson County Ret Center COUNTY Henderson

FACILITY IDPH LICENSE NUMBER 0035246

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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 Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,636 B. General Construction Type: Exterior Brick Frame wood/steel Number of Stories 1

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

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

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

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

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

3 Non-Healthcare realted rental houses.
20 Bed Supportive Living Facility

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Care Related	217,600	1988	$ 15,000	1
2					2
3	TOTALS	217,600		$ 15,000	3

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1989	1988	$ 1,260,000	$ 42,031	30	$ 42,000	$ (31)	$ 1,158,424	4
5	6		2000	2000	530,989	13,301	40	13,275	(26)	217,527	5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT/LANDSCAPING			1989	25,102		20			25,102	9
10	LANDSCAPING			1990	937		20			937	10
11	LAND IMPROVEMENT			1995	1,839		20			1,839	11
12	BRICK SIGN			1996	12,915	414	20	414		12,915	12
13	LAND IMPROVEMENT			1992	2,003		20			2,003	13
14	LIGHTNING RODS			1998	3,600		15			3,600	14
15	NEW SOFFITS			1998	26,138		15			26,138	15
16	PHONE SYSTEM			1998	6,738		15			6,738	16
17	SIDE WALKS			1998	4,500	226	20	225	(1)	4,105	17
18	ALARM SYSTEM			1998	8,266		10			8,266	18
19	LAUNDRY/GARAGE BLDG			1999	50,330		15			50,330	19
20	STORAGE BLDG			1999	8,911		15			8,911	20
21	NEW ROOF			1999	16,311		15			16,311	21
22	LANDSCAPING			2000	1,706	85	20	85		1,379	22
23	FURNICE			2001	2,848		10			2,848	23
24	NEW EXIT			2001	1,645	18	15	18		1,645	24
25	LANDSCAPING			2002	954		10			954	25
26	GARAGE/STORAGE BUILDING			2002	12,800	858	15	853	(5)	12,371	26
27	ROOFING/SHINGLES			2003	17,838	1,192	15	1,189	(3)	16,050	27
28	Walk-in Freezer			2007	20,883	1,044	20	1,044		9,484	28
29	Window Tinting			2007	2,985	150	20	149	(1)	1,374	29
30	Door Closures			2007	4,345	434	10	434		3,982	30
31	Window Tinting			2008	1,164	58	20	58		514	31
32	Generator			2009	101,961	5,098	20	5,098		38,660	32
33	Fire Sprinkler			2010	17,425	1,162	15	1,162		7,551	33
34	Sprinkler Heads			2011	17,425	1,162	15	1,162		6,680	34
35	Parking Lot/Driveway			2011	30,280	2,030	15	2,019	(11)	11,503	35
36	400 Hall-Painting Labor			2012	11,822	590	20	590		2,560	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dining Room Paint	2012	$ 5,415	$ 271	20	$ 271	$	$ 1,105	37
38	Dining Room Flooring	2012	18,677	934	20	934		3,813	38
39	400 Hall-new Handraiols, Kickplates, Wall Coverings	2012	11,842	593	20	593		2,571	39
40	Door Alarms	2013	3,272	164	20	164		545	40
41	100 Hall-Flooring	2014	27,954	1,398	20	1,398		2,912	41
42	100 Hall-Painting Labor	2014	12,011	601	20	601		1,251	42
43	100 Hall-Construction Labor	2014	20,838	1,042	20	1,042		2,171	43
44	100 Hall-Wall Coverings	2014	8,363	418	20	418		871	44
45	100 Hall-Wall Plates	2014	1,724	86	20	86		180	45
46	100 Hall-Trim	2014	1,496	75	20	75		156	46
47	100 Hall-Building Materials	2014	10,572	529	20	529		1,101	47
48	100 Hall-Doors	2014	2,116	212	10	212		441	48
49	100 Hall-Shutters	2014	1,910	191	10	191		398	49
50	Storage Unit	2015	3,975	198	20	198		217	50
51	Flooring-Old Dining Room	2015	13,789	689	20	689		747	51
52	200 Hall-paint/wall paper	2016	12,497	623	20	623		623	52
53	200 Hall Door Frame Protectors	2016	3,485	174	20	174		174	53
54	200 Hall Flooring	2016	19,944	997	20	997		997	54
55	200 Hall Labor	2016	8,500	425	20	425		425	55
56	200 Hall-Water Line	2016	7,448	372	20	372		372	56
57	200 Hall-building Material	2016	2,504	125	20	125		125	57
58	200 Hall-Labor	2016	10,560	528	20	528		528	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,413,552	$ 80,498		$ 80,420	$ (78)	$ 1,682,424	70

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

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 320,733	$ 37,057	$ 37,057	$	15	$ 180,864	71
72	Current Year Purchases	71,390	4,766	4,766		15	4,766	72
73	Fully Depreciated Assets	638,660					638,660	73
74								74
75	TOTALS	$ 1,030,783	$ 41,823	$ 41,823	$		$ 824,290	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	Patient Transportation	07 Dodge Caravan	2007	$ 17,725	$	$	$	5	$ 17,725	76
77	Patient Transportation	06 Ford E450	2008	35,095				5	35,095	77
78	Maintenance & Snow Remov	1995 Ford F250	2011	9,000	450	450		5	9,000	78
79	See List	See List	See List	47,183	9,437	9,437	0	5	26,875	79
80	TOTALS			$ 109,003	$ 9,887	$ 9,887	$ 0		$ 88,695	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,568,337	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,208	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,130	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (78)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,595,409	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	RENTAL HOUSE	$ 87,254	$ 2,965	$ 24,377	86
87	RENTAL HOUSE	60,160	2,039	3,909	87
88	RENTAL HOUSE	85,175	2,733	4,282	88
89	SUPPORTIVE LIVING	1,772,887	55,122	384,024	89
90					90
91	TOTALS	$ 2,005,476	$ 62,859	$ 416,592	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 Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	1,465	$ 122,038	$	1,465	$ 122,038	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		89	6,995		89	6,995	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,695	131,650		1,695	131,650	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				47,620		47,620	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			$	3,249	$ 260,683	$ 47,620	3,249	$ 308,303	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.

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [x] YES [ ] NO
16. Rental Amount for movable equipment: $ 3,067 Description: ($1036.18 Oxygen Rent, $1422.50 Copier rent, $608.00 Bariatric Bed Rent)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Henderson County Ret Center **#** 0035246 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 678,028	$ 779,812	1
2	Cash-Patient Deposits		(28,530)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	517,539	625,637	3
4	Supply Inventory (priced at Fifo)	26,330	33,626	4
5	Short-Term Investments			5
6	Prepaid Insurance	6,972	25,094	6
7	Other Prepaid Expenses	11,754	14,917	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,240,623	$ 1,450,556	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500	22,500	13
14	Buildings, at Historical Cost	2,680,095	4,588,616	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,246,459	1,343,414	16
17	Accumulated Depreciation (book methods)	(2,880,165)	(3,296,758)	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): CIP	79,164	79,714	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,148,053	$ 2,737,486	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,388,676	$ 4,188,042	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,827	$ 75,250	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,130	76,180	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,905	2,911	31
32	Accrued Real Estate Taxes(Sch.IX-B)		4,569	32
33	Accrued Interest Payable	2,426	5,596	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	(746)	(746)	36
37	Rounding	1	1	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 135,543	$ 163,761	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	579,797	1,769,318	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 579,797	$ 1,769,318	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 715,340	$ 1,933,079	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,673,336	$ 2,254,963	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,388,676	$ 4,188,042	48

***(See instructions.)**

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,041,884	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,041,884	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	112,295	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rental Division	(4,587)	15
16	Other (describe) Supportive Living Division	105,371	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 213,079	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,254,963	24 *

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

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,164,271	1
2	Discounts and Allowances for all Levels	(14,426)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,149,845	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	432,838	6
7	Oxygen	1,895	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 434,733	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,348	12
13	Barber and Beauty Care	4,413	13
14	Non-Patient Meals	13,034	14
15	Telephone, Television and Radio	1	15
16	Rental of Facility Space		16
17	Sale of Drugs	84,114	17
18	Sale of Supplies to Non-Patients	112	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	720	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 107,742	23
	D. Non-Operating Revenue		
24	Contributions	24,995	24
25	Interest and Other Investment Income***	9,977	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,972	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See List attached	33,184	28
28a	Fundraising	10	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 33,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,760,486	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	536,916	31
32	Health Care	1,308,970	32
33	General Administration	445,278	33
	B. Capital Expense		
34	Ownership	182,267	34
	C. Ancillary Expense		
35	Special Cost Centers	72,184	35
36	Provider Participation Fee	102,575	36
	D. Other Expenses (specify):		
37	rounding	1	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,648,191	40
41	**Income before Income Taxes (line 30 minus line 40)****	112,295	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 112,295	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 622,903	44
45	Private Pay - Net Inpatient Revenue	1,121,065	45
46	Medicare - Net Inpatient Revenue	405,877	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,149,845	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.**

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,850	2,073	$ 62,532	$ 30.16	1
2	Assistant Director of Nursing	918	1,092	25,006	22.90	2
3	Registered Nurses	4,003	4,673	114,586	24.52	3
4	Licensed Practical Nurses	10,484	11,900	247,656	20.81	4
5	CNAs & Orderlies	25,900	28,103	331,013	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,624	1,768	21,497	12.16	9
10	Activity Assistants	1,954	2,078	18,251	8.78	10
11	Social Service Workers	2,631	2,819	36,817	13.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,062	2,178	25,018	11.49	14
15	Cook Helpers/Assistants	4,508	4,877	47,696	9.78	15
16	Dishwashers	7,121	7,880	75,763	9.61	16
17	Maintenance Workers	4,205	4,455	61,531	13.81	17
18	Housekeepers	5,509	5,798	54,100	9.33	18
19	Laundry	1,861	2,148	25,059	11.67	19
20	Administrator	2,050	2,378	81,449	34.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,947	2,091	31,310	14.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan	1,820	1,951	44,503	22.81	32
33	Other(specify) Act Driver	5	5	45	9.00	33
34	TOTAL (lines 1 - 33)	80,452	88,267	$ 1,303,832 *	$ 14.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	109	$ 5,104	1-3	35
36	Medical Director	Contract	10,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,660	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,500	11-3	44
45	Social Service Consultant	16	1,250	10-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	144	$ 21,014		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	711	23,711	10-3	52
53	TOTAL (lines 50 - 52)	711	$ 23,711		53

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Valerie Lybarger-Adams	Administrator	0	$ 81,448
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,448

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
WDM Computer Services, Inc	Data Processing	$ 18,252
Bruner	Architech	
Bennet and Middendorf	Audit Services	3,292
Fort and Neff	Legal	82
DM Webdesigner	Web Services	300
Ciruit Wide Reporting	Consultant	165
Gullberg, Box, Worley	Legal	800
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 22,891

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,663
Unemployment Compensation Insurance	(926)
FICA Taxes	98,239
Employee Health Insurance	45,873
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer's IRA Match	9,430
Vacation Accrual Adjustment	
Employee Life Ins.	1,011
Employee Recognition	3,349
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 197,638

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

Description	Line #	Amount
n/a		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	3,494
Health Care Worker Background Check	199
(Indicate # of checks performed)	
Patient Background Checks	842
Advertising/Public Relations	5,652
See List Attached	4,752
Employee Drug Testing	1,745
Background Checks-Volunteers	
Less: Public Relations Expense	(5,652)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,022

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached	2,560
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,560

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. **Leading Age $2073.84**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(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? **9**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,142** Line **10-2**

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

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

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **102,575**
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? **Yes** 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? **n/a**

(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? **Yes** Indicate the amount. $ **13,034**

(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. $ **1,966**
c. What percent of all travel expense relates to transportation of nurses and patients? **95**
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. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Bennett and Middendorf**

(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

Henderson County Retirement Center, Inc.
#0035246
01/01/16 to 12/31/16

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	$2,968.13
REPAIRS & MAINT LAUNDRY	$1,288.48
REPAIRS & MAINT HSK	$0.00
OUTSIDE SERVICES	$7,570.02
REPAIRS & MAINT BUILDING	$15,918.06
REPAIRS & MAINT EQUIP	$4,433.79
REPAIRS & MAINT GROUNDS	$885.64
CABLE	$4,261.28
REFUSE	$5,709.77
REPAIRS & MAINT GEN/ADM	$3,019.99
TOTAL	$46,055.16

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	$5,465.92
Board Minutes	$275.00
Software Support	$21,797.61
TOTAL	$27,538.53

Schedule V. Line 14 & 25, Column 2 (90% to line 14)

Auto Exp. & Service	$10,249.35
Auto Gas & Oil	$2,592.17
Business Mileage Expense	$146.94
	$12,988.46

Schedule V. Line 43, Column3

Bad Debt	$15,215.50
Rounding	$1.00
	$15,216.50

Schedule V. Line 27, Column3

Data Process-Internet	$51.20
Contributions	$471.00
Misc Exp.	$2,067.07
Rounding	
bank fees	
	$2,589.27

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Transportation Income-Pvt	$8,721.25
Transportation Income-IDPA	$1,966.22
Suppliments	$6,480.00
WheelChair Rental	$0.00
Admission Income	$600.00
Uniform Sales	$0.00
Activities Program Income	$0.00
Personal Purchase income	$0.00
SLF Allocations-Clerical	$2,833.32
SLF Allocations-Maintenance	$9,999.96
Gain or Loss on Sale of Asset	$500.00
Rebates	$262.00
Discounts	$0.00
Dues	$1,175.00
Misc. Income	$646.43
Rounding	
	$33,184.18

Schedule XIX, Section F.

Leading Age	Dues	$2,073.84
Point Click Care	Dues	$743.00
Hawkeye	Subscription	$192.40
Misc Subscriptions	Subscription	$93.88
Poster Compliance	Subscription	$79.00
Creative Forecasters	Subscription	$60.00
Med Pass	Subscription-Policy & Procedures	$372.60
Activity Connect	Web Subscription/Dues	$286.80
CLIA Cert	Certification	$150.00
IDPH	Sanitation Lic.	$105.00
IL Charity Buraeu	990-g Fee	$10.00
Secretary of State	Fees	$121.00
V. Lyberger	Admin Lic	$425.00
Safe Deposit Box		$9.00
CNASU	Fees	$30.00
Rounding		
		$4,751.52

Schedule XI, Section D.

	Use	Make, Model and Year	Year Acquired	Cost	Current Book Depreciation	Striaght Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
79	Patient Transport	Van	2012	$9,105.00	$1,821.00	$1,821.00		5	$9,105.00
80	Patient Transport	2014 Dodge Car	2014	########	$7,615.68	$7,615.68		5	$17,769.92
				########	$9,436.68	$9,436.68	$0.00		$26,874.92

Henderson County Retirement Center, Inc.
#0035246
01/01/16 to 12/31/16

Board Members

Diana Doran, Pres
Box 417
Carman, IL 61425

Jayne Olson
Box 1
Gladstone, IL 61437

Mary Reed, Treas.
RR 1, Box 80
Little York, IL 61453

Nancy Stevenson, Sec.
RR 1
Gladstone, IL 61437

Ralph Tatge,Vice Pres.
Box 535
Stronghurst, IL 61480

Judy Roessler
RR1, Box 11
Media, IL 61460

Tom Edmonds
RR 1, Box 129
Lomax, IL 61454

Tom Pullen
Box 199
Gladstone, IL 61437

David Gerst
RR 1, Box 111
Lomax, IL 61454

Honorary Board Members
Laura Kent Donahue
Zach Stamp

Diana Doran's insurance agency is the agent for the Commercial Package Policy.
The agency also provides the surety bond for the nursing home.

Henderson County Retirement Center, Inc.
#0035246
01/01/16 to 12/31/16

Reclasssifications

1 Reclassify $125.00 out of OT outside service to Social Services outside services due to coding error.

2 Reclassify $

3 Reclassify $

4 Reclassify $

5 Reclassify $

6 Reclassify $

Henderson County Retirement Center, Inc.
#0035246
01/01/16 to 12/31/16

Schedule V. Line 23, Column 3

Check Date	When Attended	Vendor Name	Name of In-Service	Amount
1/27/2016	2/16/2016	Leading Age Illinois	QAPI-	$ 99.00
1/29/2016	2/16/2016	Leading Age Illinois	Medicare Updates 2016	$109.00
2/3/2016	2/23/2017	Polaris Group	New MDS Focused Survey	$139.00
2/5/2016	2/17/2016	WipfliLLlp	QAPI-The Final Rule Is Almost Ready	$ 99.00
3/10/2016	2/22/2016	Channing Bete Company	BLS Instructor Package	$ 57.23
2/12/2016			Paid for CPR Card	$ (2.00)
3/1/2016	2/9/2016	GPS Healthcare Consultants	Therapy in SNF is NOT your Grandm	$129.00
3/10/2016	3/8/2016	Blessing Hospital	CPR cards for CPR training	$ 12.00
3/28/2016		Barbara Karnes Books, Inc.	DVD's for End of Life - for In Service	$ 33.00
5/2/2016	5/10/2016	GPS Healthcare Consultants	Minding Your Qs and Ps (Dealing wit	$129.00
4/8/2016	4/16/2016	GPS Healthcare Consultants	Back to the Future Is Now!	$129.00
5/13/2016	5/12/2016	Blessing Hospital	CPR cards for CPR training	$ 30.00
6/1/2016	6/14/2016	GPS Healthcare Consultants	The MDS Iten Set Is Changing…Aga	$129.00
6/17/2016	6/11/2016	Blessing Hospital	CPR cards for CPR training	$ 5.00
6/25/2016	7/19/2016	Polaris Group	Medicare Secondary Payer	$149.00
7/2/2016	7/3/2016	TAP Series	Food Handler Training Course	$ 61.25
7/20/2016	7/13/2016	Blessing Hospital	CPR cards for CPR training	$ 10.00
7/22/2016	8/17/2016	WipfliLLlp	RAI-Upcoming Changes and Strategi	$ 99.00
8/25/2016	5/12/2016	Blessing Hospital	CPR cards for CPR training - shorted	$ 10.00
9/16/2016	9/14/2016	Blessing Hospital	CPR cards for CPR training	$ 5.00
10/24/2016	10/14/2016	Blessing Hospital	CPR cards for CPR training	$ 7.00
3/24/2016		N. Morris	Food Service Book	$221.40
3/24/2016		N. Morris	Food Service Training	$550.00
3/30/2016		N. Morris	Food Service Training	$ 64.80
10/17/2016		V. Adams	State Boards	$ 96.28
11/9/2016		V. Adams	Paypal Book-Administrator testing	$199.00
				$ 2,569.96

Henderson County Retirement Center, Inc.
#0035246
01/01/16 to 12/31/16

Schedule V. Line 24, Column 3

Check Date	Who Attended	When Attended	Where Attended	Name of Seminar	Expense	Amount	Totals
6/3/2016	Dianne Kircher	7/12/2016	Springfield, IL	On The Road With Medicare Summer 2016	Registration	$ 110.00	$ 110.00
2/25/2016	Nicole Morris, A. Worley, A. Brown	3/8/2016	Galesburg, IL	Food Safety Training	Registration	$598.00	$ 598.00
5/23/2016	Bobbi Tapscott & Dianne Kircher	5/24/2016	Springfield, IL	Medicaid Electronic Billing	Fuel	$ 14.70	$ 14.70
5/24/2016	Bobbi Tapscott & Dianne Kircher	5/24/2016	Springfield, IL	Medicaid Electronic Billing	Fuel	$ 20.46	$ 20.46
7/15/2016	Dianne Kircher	7/12/2016	Springfield, IL	On The Road With Medicare Summer 2016-Meals	Meals	$ 5.19	$ 5.19
7/15/2016	Dianne Kircher	7/12/2016	Springfield, IL	On The Road With Medicare Summer 2016-Fuel	Fuel	$ 18.60	$ 18.60
7/29/2016	Same as above	8/29/2016	Stronghurst, IL	HFS Passenger Assist. Classroom Training	Registration	$ 600.00	$ 600.00
8/9/2016	J. Hetrick, M. Hopkins, P. Clark, J. Hetrick, K. Kaczinski, C. Hay	8/9/2016	Stronghurst, IL	HFS Passenger Assist. Classroom Training	Food	$ 51.29	$ 51.29
8/16/2016	Same as above	8/29/2016	Stronghurst, IL	HFS Passenger Assist. Classroom Training	Use of church	$ 50.00	$ 50.00
9/21/2016	Paula Clark and Misty Tenenbaum	9/21/2016	East Peoria, IL	Activity Director 36 hours Training Course	Registration	$ 250.00	$ 250.00
9/23/2016	Paula Clark and Misty Tenenbaum	9/21/2016	East Peoria, IL	Activity Director 36 hoursTraining Course	Meals	$ 19.40	$ 19.40
9/23/2016	Paula Clark and Misty Tenenbaum	9/21/2016	East Peoria, IL	Activity Director 36 hoursTraining Course	Fuel	$ 20.60	$ 20.60
10/10/2016	Valerie Hinderliter	11/9/2016	Peoria, IL	Health Service Consultants, Inc.	Registration	$ 240.00	$ 240.00
10/21/2016	West Central FS	10/21/2016	East Peoria, IL	Activity Director 36 hour Training Course	Fuel	$ 16.01	$ 16.01
10/21/2016	West Central FS	10/21/2016	East Peoria, IL	Activity Director 36 hour Training Course	Fuel	$ 15.24	$ 15.24
10/24/2016	Paula Clark , Carole Dillon and Misty Tene	10/21/2016	Moline IL	Activity Director 36 hour Training Course	Meals	$ 17.73	$ 17.73
10/26/2016	Paula Clark , Carole Dillon and Misty Tene	11/4/2016	Moline IL	Rick Ramirez Training Conference	Registration	$ 250.00	$ 250.00
11/11/2016	Valerie Hinderliter	11/9/2016	Champaign, IL	Health Service Consultants, Inc.	Hotel	$ 123.17	$ 123.17
11/11/2016	Valerie Hinderliter	11/9/2016	Champaign, IL	Health Service Consultants, Inc.	Mileage	$139.50	$ 139.50
				Total Seminars		$ 2,559.89	$ 2,559.89