

		FOR BHF USE					

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**2017**  
 STATE OF ILLINOIS  
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
 FOR LONG-TERM CARE FACILITIES  
 (FISCAL YEAR 2017)

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

<p><b>I. IDPH License ID Number:</b> <u>0042275</u></p> <p><b>Facility Name:</b> <u>Zachary House</u></p> <p><b>Address:</b> <u>1102 East Avenue</u> <u>Streamwood</u> <u>60107</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(630) 483-0537</u> Fax # <u>(630) 483-0537</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>12/16/96</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p>In the event there are further questions about this report, please contact:  <b>Name:</b> <u>Robin Witt</u> Telephone Number: <u>(630) 483-0537</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2017</u> to <u>12/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____            (Date) _____            (Type or Print Name) <u>Robin Witt</u>            (Title) <u>Administrator</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) _____            (Date) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) ( ) _____ Fax # ( ) _____         </td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630       </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____ (Type or Print Name) <u>Robin Witt</u> (Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____ (Type or Print Name) <u>Robin Witt</u> (Title) <u>Administrator</u>							
<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

STATE OF ILLINOIS

Facility Name & ID Number Zachary House

# 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	16	TOTALS	16	<u>5,840</u>	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	<u>5,470</u>			<u>5,470</u>	13
14	TOTALS	5,470			5,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.66%

D. How many bed-hold days during this year were paid by the Department? 14 (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 12/16/96

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

YES  Date 12/16/96 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 \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAU  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

STATE OF ILLINOIS

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017  
 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
1	A. General Services										
1	Dietary	48,279	1,616	1,191	51,086	(2,983)	48,103		48,103		1
2	Food Purchase		37,523		37,523		37,523		37,523		2
3	Housekeeping		12,284		12,284		12,284		12,284		3
4	Laundry		2,276		2,276		2,276		2,276		4
5	Heat and Other Utilities			14,665	14,665		14,665		14,665		5
6	Maintenance	2,948	145	10,360	13,453		13,453		13,453		6
7	Other (specify):*										7
8	TOTAL General Services	51,227	53,844	26,216	131,287	(2,983)	128,304		128,304		8
9	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	179,320	2,465	9,377	191,162		191,162		191,162		10
10a	Therapy										10a
11	Activities		96		96		96		96		11
12	Social Services			851	851		851		851		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	179,320	2,561	10,228	192,109		192,109		192,109		16
17	C. General Administration										
17	Administrative	40,000			40,000		40,000		40,000		17
18	Directors Fees										18
19	Professional Services			6,350	6,350		6,350		6,350		19
20	Dues, Fees, Subscriptions & Promotions			298	298		298		298		20
21	Clerical & General Office Expenses		260	51,019	51,279		51,279	(2,154)	49,125		21
22	Employee Benefits & Payroll Taxes			22,262	22,262	2,983	25,245	2,300	27,545		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							13,609	13,609		26
27	Other (specify):*										27
28	TOTAL General Administration	40,000	260	79,929	120,189	2,983	123,172	13,755	136,927		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	270,547	56,665	116,373	443,585		443,585	13,755	457,340		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 Zachary House #0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

## 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	
30	D. Ownership											
	Depreciation			3,182	3,182		3,182	24,358	27,540			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			39,092	39,092		39,092	(3,494)	35,598			33
34	Rent-Facility & Grounds			156,000	156,000		156,000	(156,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			198,274	198,274		198,274	(135,136)	63,138			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,057	1,110	3,167		3,167		3,167			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,568	45,568		45,568		45,568			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,057	46,678	48,735		48,735		48,735			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	270,547	58,722	361,325	690,594		690,594	(121,381)	569,213			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 Zachary House # 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals		2.2		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	24,358	30.3		9
10 Interest and Other Investment Income		32.3		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
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees		13		27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	-			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 24,358		\$	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	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(145,739)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (145,739)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (121,381)		37

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

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

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

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
Byrn T. Witt	50.00%	Meadows	Rolling Meadows			
Barbara S. Witt	50.00%	Meadows	Rolling Meadows			

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V	21 Personnel, Accounting, Etc.		Meadows		13,275	13,275	5
6	V	21 General Office Supplies		Meadows		2,188	2,188	6
7	V	21 General Office Other		Meadows		6,383	6,383	7
8	V	22 Employee Benefits		Meadows		2,300	2,300	8
9	V	21 Administrative Overhead	24,000	Meadows			(24,000)	9
10	V	34 Facility Rent	156,000	Byrn T. Witt & Barbara S. Witt	100.00%		(156,000)	10
11	V							11
12	V	26 Insurance		Meadows		13,609	13,609	12
13	V	33 Real Estate Tax	39,092	Byrn T. Witt & Barbara S. Witt	100.00%	35,598	(3,494)	13
14	Total		\$ 219092			\$ 73,353	\$ * (145,739)	14

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

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Zachary House # 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Meadows Sheltered Care, Inc.  
 Street Address 3250 South Plum Grove Road  
 City / State / Zip Code Rolling Meadows, IL 60008  
 Phone Number (847) 397-0055  
 Fax Number (847) 397-0477

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

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	21.1	Office	Direct Cost	6,612	2	187,572	187,572	468	13,275	2
3										3
4										4
5	21.2	Office Supplies	Expenses	2,555,697	2	13,313	420,047		2,188	5
6	21.3	Office Other	Expenses	2,555,697	2	38,834	420,047		6,383	6
7	22.3	Employee Benefits	Salary	2,397,997	2	415,488	13,275		2,300	7
8	26.3	Insurance	Expenses	2,555,697	2	82,803	420,047		13,609	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					\$ 738,010	\$ 187,572		\$ 37,755	25



Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

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

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

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

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

Facility Name & ID Number Zachary House

# 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)  
 B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.		\$	39,092	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.)		\$	37,345			2		
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,747)			3		
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	37,345			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.		\$	35,598			7		
Real Estate Tax History:								
Real Estate Tax Bill for Calendar Year:	2012	33,522	8	FOR BHF USE ONLY				
	2013	37,272	9					
	2014	38,420	10			13	FROM R. E. TAX STATEMENT FOR 2016 \$	13
	2015	39,092	11			14	PLUS APPEAL COST FROM LINE 5 \$	14
	2016	37,345	12			15	LESS REFUND FROM LINE 6 \$	15
Accrual based on current year assessment.				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.**

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Zachary House COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0042275  
 CONTACT PERSON REGARDING THIS REPORT Robin Witt  
 TELEPHONE (630) 483-0537 FAX #: (630) 483-0537

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-25-301-043-0000</u>	<u>1100 East Avenue</u>	\$ <u>37,345.00</u>	\$ <u>37,345.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>37,345.00</u>	\$ <u>37,345.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   x   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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,680 B. General Construction Type: Exterior Brick & Siding Frame Wood 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).

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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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>ICF/DD 16</u>	<u>52,695</u>	<u>1995</u>	<u>\$ 145,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>52,695</u>		<u>\$ 145,000</u>	<u>3</u>

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		1996	1996	\$ 509,864	\$	39	\$ 13,073	\$ 13,073	\$ 274,533	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Landscaping		1997	16,650		39	427	427	8,804	9
10		Time Clock Sytem		1999			5				10
11		Floor Covering		2002	2,985		7			2,985	11
12		Wall Covering		2002	672		7			672	12
13		Bathroom cabinetry		2010			7				13
14		Driveway installation		2010			15				14
15		Kitchen countertop and cabinetry		2014	3,195	183	7	456	273	1,407	15
16		New building roof		2014	16,970	566	15	1,131	565	3,582	16
17		New flooring inside house		2014	6,183	206	15	412	206	1,248	17
18		New flooring inside house		2015	28,468	949	15	1,898	949	5,689	18
19		Window blinds throughout building		2015	2,741	240	7	392	152	784	19
20		Driveway back area		2016	4,410		15	294	294	318	20
21		Central sprinkler system life safety		2016	6,991		15	466	466	621	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	\$ 28,926	\$ 366	\$ 366		5	\$ 26,332	71
72	Current Year Purchases	672	672	134	(538)	5	134	72
73	Fully Depreciated Assets	7,306					7,306	73
74								74
75	TOTALS	\$ 36,904	\$ 1,038	\$ 500	\$ (538)		\$ 33,772	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78	Patient Transport	2006 Ford Van	2006	31,971				5	31,970	78
79	Patient Transport	2016 Ford Van	2016	42,455		8,491	8,491	5	16,982	79
80	TOTALS			\$ 74,426	\$	\$ 8,491	\$ 8,491		\$ 48,952	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)	\$ 855,459	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,182	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,540	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,358	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 383,367	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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	TOTAL		\$	\$	21

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

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

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

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

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ \_\_\_\_\_

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.



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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$		\$					\$			1
2	Licensed Speech and Language Development Therapist	10a.3	hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a.3	hrs													4
5	Physician Care	39.3	visits													5
6	Dental Care	39.3	visits			15	1,110					15		1,110		6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39.2	# of prescrpts								2,057			2,057		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Exceptional Care</u>	39.2														12
13	Other (specify): <u>Medical Supplies</u>	39.2														13
14	TOTAL			\$		15	\$ 1,110	\$	2,057		15	\$	3,167		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.

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,561,710	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	42,609		3
4	Supply Inventory (priced at FIFO )	865		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(56,415)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,548,769	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	67,356		15
16	Equipment, at Historical Cost	100,602		16
17	Accumulated Depreciation (book methods)	(145,093)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,865	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,571,634	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 14,362	\$	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)	1,747		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 16,109	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,109	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,555,525	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,571,634	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,409,477	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	45,119	4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,454,596	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	100,929	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 100,929	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 1,555,525	24 *

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

STATE OF ILLINOIS

Facility Name & ID Number Zachary House

# 0042275

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 789,054	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 789,054	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
<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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,469	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,469	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 791,523	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	131,287	31
32	Health Care	192,109	32
33	General Administration	120,189	33
<b>B. Capital Expense</b>			
34	Ownership	198,274	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,167	35
36	Provider Participation Fee	45,568	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 690,594	40
41	Income before Income Taxes (line 30 minus line 40)**	100,929	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 100,929	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 789,054	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Rounding</u>		47
48	Other-(specify) <u>Rounding</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 789,054	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.

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				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	3,674	4,024	48,278	12.00
16	Dishwashers				16
17	Maintenance Workers	178	178	2,948	16.56
18	Housekeepers				18
19	Laundry				19
20	Administrator	787	787	40,000	50.85
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	468	468	13,275	28.37
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	486	486	15,000	30.86
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	10,740	11,251	164,320	14.60
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	16,333	17,194	\$ 283,822 *	\$ 16.51

\* 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	\$ 897	1.3
36	Medical Director			36
37	Medical Records Consultant			10.3
38	Nurse Consultant	248	8,682	10.3
39	Pharmacist Consultant	12	695	10.3
40	Physical Therapy Consultant			10a.3
41	Occupational Therapy Consultant			10a.3
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant			10a.3
44	Activity Consultant			
45	Social Service Consultant			12.3
46	Other(specify) <u>Psychiatrist</u>	3	851	12.3
47				
48				12.3
49	TOTAL (lines 35 - 48)	298	\$ 11,125	

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



Facility Name &amp; ID Number Zachary House

# 0042275

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

## 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? No  
If YES, give association name and amount. \_\_\_\_\_
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ - 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. \$ 45,568  
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. \$ 2,983 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
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? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 12,509
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (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.