

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

<p>I. IDPH License ID Number: <u>0036947</u></p> <p>Facility Name: <u>GROUP HOME #1</u></p> <p>Address: <u>212 BACHMAN LANE</u> <u>GODFREY</u> <u>62035</u> Number City Zip Code</p> <p>County: <u>MADISON</u></p> <p>Telephone Number: <u>(618) 466-0367</u> Fax # <u>(618) 466-3652</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/19/1991</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BRENDA MILLER</u> Telephone Number: <u>(618) 466-0367</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2017</u> to <u>6/30/2018</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 border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>BRENDA MILLER</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>FINANCE DIRECTOR</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>DANIEL E. PHIPPS</u> <u>PRINCIPAL</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>106 W. COUNTY ROAD, JERSEYVILLE, IL 62052</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(618) 498-6841</u> Fax # <u>(618) 498-6842</u></td> <td></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>BRENDA MILLER</u>			(Title) <u>FINANCE DIRECTOR</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>DANIEL E. PHIPPS</u> <u>PRINCIPAL</u>		(Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>106 W. COUNTY ROAD, JERSEYVILLE, IL 62052</u>		(Telephone) <u>(618) 498-6841</u> Fax # <u>(618) 498-6842</u>	
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Facility Name & ID Number GROUP HOME #1

0036947 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,863	196		5,059	13
14	TOTALS	4,863	196		5,059	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.63%

D. How many bed reserve days during this year were paid by the Department? 383 (Do not include bed reserve 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 07/19/1991

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/19/1991 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	952	19		971		971	971			1
2	Food Purchase		27,790		27,790		27,790	27,790			2
3	Housekeeping	18,486	3,543		22,029		22,029	22,029			3
4	Laundry										4
5	Heat and Other Utilities			17,166	17,166		17,166	17,166			5
6	Maintenance	19,750	7,683	8,397	35,830		35,830	35,830			6
7	Other (specify):* SECURITY	2,605	9	5,630	8,244		8,244	8,244			7
8	TOTAL General Services	41,793	39,044	31,193	112,030		112,030	112,030			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	253,040	2,537		255,577	(4,632)	250,945	250,945			10
10a	Therapy										10a
11	Activities	4,178	2,100	105	6,383		6,383	6,383			11
12	Social Services										12
13	CNA Training					4,632	4,632	4,632			13
14	Program Transportation	5,963			5,963		5,963	5,963			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	263,181	4,637	105	267,923		267,923	267,923			16
	C. General Administration										
17	Administrative	25,276		8,379	33,655	6,600	40,255	40,255			17
18	Directors Fees										18
19	Professional Services			6,641	6,641		6,641	6,641			19
20	Dues, Fees, Subscriptions & Promotions			2,955	2,955		2,955	2,955			20
21	Clerical & General Office Expenses	36,626	3,969	7,813	48,408		48,408	48,408			21
22	Employee Benefits & Payroll Taxes			76,332	76,332		76,332	76,332			22
23	Inservice Training & Education										23
24	Travel and Seminar			427	427	(57)	370	370			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			20,876	20,876		20,876	20,876			26
27	Other (specify):*										27
28	TOTAL General Administration	61,902	3,969	123,423	189,294	6,543	195,837	195,837			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	366,876	47,650	154,721	569,247	6,543	575,790	575,790			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.

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	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			30,244	30,244		30,244		30,244		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			25,793	25,793	(6,543)	19,250		19,250		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* MORTGAGE INS.			1,952	1,952		1,952		1,952		36
37	TOTAL Ownership			57,989	57,989	(6,543)	51,446		51,446		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,116	40,116		40,116		40,116		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			40,116	40,116		40,116		40,116		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	366,876	47,650	252,826	667,352		667,352		667,352		45

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

GROUP HOME #1

ID# 0036947

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BEVERLY FARM FOUNDATION	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #5	GODFREY			
		GROUP HOME #6	GODFREY			

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

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

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

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

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	BOARD OF DIRECTORS	BOD	BOD	0.00	NONE	7	0.00		\$ 0	N/A	1
2	(SEE PAGE 6)										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 GROUP HOME #1 # 0036947 Report Period Beginning: 7/1/2017 Ending: 5/30/2018

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

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

Name of Related Organization BEVERLY FARM FOUNDATION & GROUP HOMES #2, #3, #4, #5, & #6
 Street Address GODFREY, IL 62035
 City / State / Zip Code (618) 466-0367
 Phone Number (618) 466-3652
 Fax Number

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	\$ 3,881,876	\$ 197	\$ 76,332	1
2	17-3	OUTSOURCING-IT/PAYROLL	WAGES	10,000	8	159,301	307	4,891	2
3	17-1	ADMINISTRATIVE SALARIES	HOURS	2,080	8	323,107	323,107	16,155	3
4	17-3	ADMINISTRATIVE-OTHER	HOURS	2,080	8	170,294	43	3,488	4
5	21-1	PERSONNEL-ACCOUNTING	HOURS	2,080	8	732,519	732,519	36,626	5
6	6-1	MAINTENANCE STAFF	HOURS	2,080	8	394,998	394,998	19,750	6
7	7-3	SECURITY/SAFETY	HOURS	2,080	8	112,608	104	5,630	7
8	7-1	SAFETY MANAGER	HOURS	2,080	8	52,097	52,097	2,605	8
9	7-2	SECURITY SUPPLIES	HOURS	2,080	8	171	104	9	9
10	6-2	MAINTENANCE SUPPLIES	HOURS	2,080	8	145,500	104	7,275	10
11	21-2	OSHA REQUIREMENTS	HOURS	2,080	8	67,349	104	3,367	11
12	21-3	CONSULTANTS	HOURS	2,080	8	127,991	104	6,399	12
13	6-3	MAINTENANCE-OTHER	HOURS	2,080	8	60,854	104	3,042	13
14	26-3	INSURANCE	HOURS	2,080	8	417,528	104	20,876	14
15	19-3	LEGAL& ACCOUNTING	HOURS	2,080	8	213,067	65	6,641	15
16	14-1	TRANSPORTATION STAFF	HOURS	2,080	8	119,257	119,257	5,963	16
17	20-3	DUES/SUBS/ADVERTISING	HOURS	2,080	8	86,612	71	2,955	17
18	36-3	MORTGAGE INSURANCE	HOURS	2,080	8	39,035	104	1,952	18
19	32-3	INTEREST	HOURS	2,080	8	515,857	104	25,793	19
20	24-3	TRAVEL & SEMINAR	HOURS	2,080	8	8,530	104	427	20
21	11-1	ACTIVITIES STAFF	HOURS	2,080	8	83,558	83,558	4,178	21
22	11-2	ACTIVITIES SUPPLIES	HOURS	2,080	8	11,816	104	591	22
23	11-3	ACTIVITIES OTHER	HOURS	2,080	8	2,094	104	105	23
24									24
25	TOTALS					\$ 7,726,019	\$ 1,705,536	\$ 255,050	25

Facility Name & ID Number

GROUP HOME #1

0036947

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	GERSHMAN MORTGAGE		X	REFINANCE BONDS	\$2,946.00	9/09/13	\$ 460,755	\$ 377,749	08/01/32	0.0417	\$ 16,284	1								
2	AMORTIZATION OF DEBT COSTS		X								294	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LIBERTY BANK		X	WORKING CAPITAL		4/21/18	52,500	52,500	04/21/19	0.0500	2,672	6								
7												7								
8												8								
9	TOTAL Facility Related				\$2,946.00		\$ 513,255	\$ 430,249			\$ 19,250	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 513,255	\$ 430,249			\$ 19,250	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 1,952 Line # 36-3

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 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 2018 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:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROUP HOME #1 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0036947

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 2017 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 2017.

	(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.	_____	_____	\$ _____	\$ _____
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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number GROUP HOME #1

0036947 Report Period Beginning:

7/1/2017 Ending:

6/30/2018

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: FACILITY, 10,000, \$ 5,000. Row 2: (blank), (blank), (blank). Row 3: TOTALS, 10,000, \$ 5,000.

Facility Name & ID Number GROUP HOME #1

0036947

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

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			1991	\$ 380,640	\$ 9,516	40	\$ 9,516	\$	\$ 256,139	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		BUILDING IMPROVEMENTS		1995	188		5			188	9
10		BUILDING IMPROVEMENTS		1999	3,738		VAR			3,738	10
11		BUILDING IMPROVEMENTS		2002	3,886		10			3,886	11
12		BUILDING IMPROVEMENTS		2003	3,726		5			3,726	12
13		BUILDING IMPROVEMENTS		2005	12,759	559	VAR	559		8,569	13
14		BUILDING IMPROVEMENTS		2006	272		5			272	14
15		BUILDING IMPROVEMENTS		2014	4,475	488	VAR	488		2,116	15
16		FRONT DOOR		2015	1,850	185	10	185		509	16
17		BATHROOM FLOORING		2016	1,009	101	10	101		219	17
18		KITCHEN BACKSPLASH AND LAUNDRY ROOM		2016	4,742	474	10	474		948	18
19		MED ROOM DOOR AND FRAME		2016	1,180	118	10	118		246	19
20		BATHROOM FLOORING		2017	4,696	470	10	470		665	20
21		REPLACE ALL 18 WINDOWS		2017	12,207	1,221	10	1,221		1,323	21
22		HALLWAY DOOR		2017	1,598	160	10	160		173	22
23		NEW DOORS ON BACK OF BUILDING		2017	2,630	153	10	153		153	23
24		NEW DRY PENDANTS FOR SPRINKLERS		2017	17,019	510	25	510		510	24
25		NEW FLOORING-WHOLE BUILDING		2017	4,062	237	10	237		237	25
26		NEW PAINT - WHOLE BUILDING		2018	8,130	407	5	407		407	26
27		BUILDING IMPROVEMENTS-ALLOCATED		1996	55,608	1,389	VAR	1,389		29,890	27
28		BUILDING IMPROVEMENTS-ALLOCATED		1997	860		VAR			860	28
29		BUILDING IMPROVEMENTS-ALLOCATED		1998	941		15			941	29
30		BUILDING IMPROVEMENTS-ALLOCATED		1999	52	3	20	3		48	30
31		BUILDING IMPROVEMENTS-ALLOCATED		2000	27	1	20	1		24	31
32		BUILDING IMPROVEMENTS-ALLOCATED		2004	63		10			63	32
33		BUILDING IMPROVEMENTS-ALLOCATED		2012	239	16	VAR	16		166	33
34		BUILDING IMPROVEMENTS-ALLOCATED		2013	2,785	279	VAR	279		2,297	34
35		BUILDING IMPROVEMENTS-ALLOCATED		2014	885	123	10	123		512	35
36		ADMIN BUILDING-PARKING LOT-ALLOCATED		2015	210	42	5	42		126	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 GROUP HOME #1

0036947

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	MAINT-SEWER MAIN REPAIR-ALLOCATED	2015	\$ 682	\$ 68	10	\$ 68	\$	\$ 204	37
38	MAINT-DOOR AND FRAME-ALLOCATED	2015	91	9	10	9		27	38
39	MAINT-FLOOR COVERINGS-ALLOCATED	2015	43	9	5	9		26	39
40	MAINT-REPLACED SIDEWALKS-ALLOCATED	2015	231	46	5	46		123	40
41	MAINT-REPLACED SPRINKLERS-ALLOCATED	2015	154	31	5	31		93	41
42	MAINT-NEW 42X64 BUILDING-ALLOCATED	2016	2,418	121	20	121		262	42
43	MAINT-AIR CONDITIONER UNITS-ALLOCATED	2016	1,432	143	10	143		310	43
44	MAINT-CEILING TILE-ALLOCATED	2016	128	26	5	26		55	44
45	MAINT-CLOSET LOCKS-ALLOCATED	2016	125	25	5	25		54	45
46	MAINT-CORNER GUARDS-ALLOCATED	2016	95	19	5	19		38	46
47	MAINT-DOOR LOCKSETS-ALLOCATED	2016	348	35	10	35		78	47
48	MAINT-NEW FIRE ALARM PANEL-ALLOCATED	2016	268	54	5	54		125	48
49	MAINT-PAINTING-ALLOCATED	2016	301	60	5	60		121	49
50	MAINT-REPLACE FIRE ALARMS-ALLOCATED	2016	824	82	10	82		165	50
51	MAINT-REPLACED SEWER LINES-ALLOCATED	2016	148	15	10	15		36	51
52	MAINT-REPLACED WATER HEATER-ALLOCATED	2016	427	43	10	43		96	52
53	GUARD SHACK- AIR CONDITIONER-ALLOCATED	2017	39	4	10	4		5	53
54	MAINT-STEEL ENTRY DOOR-ALLOCATED	2017	273	27	10	27		27	54
55	MAINT-CONCRETE PAD FOR PROPANE TANK-ALLOCATE	2017	70	7	10	7		9	55
56	MAINT-FIBER OPTIC PROJECT-ALLOCATED	2017	25,643	855	25	855		855	56
57	MAINT-FRONT DOOR-ALLOCATED	2017	289	24	10	24		24	57
58	MAINT-SPRINKLER HEADS-ALLOCATED	2017	185	7	25	7		7	58
59	MAINT-FIRE ALARMS-ALLOCATED	2017	144	9	15	9		9	59
60	MAINT-FIRE SPRINKLER-ALLOCATED	2017	432	13	25	13		13	60
61	ADMIN-FLOORING ENTIRE BUILDING-ALLOCATED	2018	1,954	16	10	16		16	61
62	ADMIN-AIR CONDITIONER COMPUTER ROOM-ALLOCATI	2018	338	17	5	17		17	62
63	MAINT-CONCRETE FLOOR-MAINT SHED-ALLOCATED	2017	550	25	15	25		25	63
64	ADMIN-NEW CONCRETE AT FRONT ENTRANCE-ALLOCA	2018	270	3	15	3		3	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 568,379	\$ 18,245		\$ 18,245	\$	\$ 321,774	70

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

Facility Name & ID Number GROUP HOME #1

0036947

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

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	\$ 58,041	\$ 8,337	\$ 8,337	\$	5-10	\$ 34,475	71
72	Current Year Purchases	8,487	1,018	1,018		5-10	1,018	72
73	Fully Depreciated Assets	49,156	743	743		5-10	49,156	73
74								74
75	TOTALS	\$ 115,684	\$ 10,098	\$ 10,098	\$		\$ 84,649	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SEE ATTACHED SCHEDULE			\$ 50,301	\$ 1,901	\$ 1,901	\$	5-10	\$ 43,347	76
77										77
78										78
79										79
80	TOTALS			\$ 50,301	\$ 1,901	\$ 1,901	\$		\$ 43,347	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)	\$ 739,364	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,244	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,244	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 449,770	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

GROUP HOME #1

0036947

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>84</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>90</u></p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	100	50		150
3	Classroom Wages (a)	576	1,452		2,028
4	Clinical Wages (b)		1,440		1,440
5	In-House Trainer Wages (c)	676	338		1,014
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 1,352	\$ 3,280	\$	\$ 4,632
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,632			

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
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	6

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

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

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,501,738		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,501,738	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	568,379		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	165,985		16
17	Accumulated Depreciation (book methods)	(449,770)		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)	\$ 289,594	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,791,332	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	LINE OF CREDIT	52,500		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 52,500	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	377,749		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)	\$ 377,749	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 430,249	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,361,083	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,791,332	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,322,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,322,243	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	38,840	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)	\$ 38,840	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)	\$ 1,361,083	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number GROUP HOME #1

0036947

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 706,192	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 706,192	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 706,192	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	112,030	31
32	Health Care	267,923	32
33	General Administration	195,837	33
B. Capital Expense			
34	Ownership	51,446	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,116	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 667,352	40
41	Income before Income Taxes (line 30 minus line 40)**	38,840	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 38,840	43

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

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

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

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

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

Facility Name & ID Number **GROUP HOME #1**

0036947

Report Period Beginning: 7/1/2017

Ending:

6/30/2018

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	254	4,178	15.19	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	100	952	9.52	15
16	Dishwashers				16
17	Maintenance Workers	1,342	19,750	13.95	17
18	Housekeepers	2,054	18,486	9.00	18
19	Laundry				19
20	Administrator	551	18,897	32.98	20
21	Assistant Administrator	104	3,429	32.97	21
22	Other Administrative	400	6,736	16.71	22
23	Office Manager				23
24	Clerical	1,997	32,840	14.49	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,080	47,806	17.84	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	17,599	205,234	11.38	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>SEE ATTACHED</u>	483	8,568	16.60	33
34	TOTAL (lines 1 - 33)	26,964	\$ 366,876 *	\$ 12.91	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MARTHA WARFORD	EXECUTIVE DIRECTOR	0	\$ 4,775	Workers' Compensation Insurance	\$ 18,571	IDPH License Fee	\$	
VICKY PALMER-VOGT	EXECUTIVE DIRECTOR	0	5,000	Unemployment Compensation Insurance	1,829	Advertising: Employee Recruitment	1,078	
DEBBIE REED	ASSISSTANT DIRECTOR	0	3,429	FICA Taxes	28,283	Health Care Worker Background Check		
BRENDA MILLER	FINANCIAL COORD	0	2,951	Employee Health Insurance	22,469	(Indicate # of checks performed <u>2</u>)	447	
RACHEL LOLLIS	ADMINISTRATOR	0	7,988	Employee Meals		Patient Background Checks <u>1</u>	223	
KRYSTAL GRUENFELDER	ADMINISTRATOR	0	1,133	Illinois Municipal Retirement Fund (IMRF)*		DUES/SUBS/LICENSE FEES	259	
				PENSION	2,222	IHCA DUES	948	
				MISC EMPLOYEE BENEFITS	2,958			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 25,276					
B. Administrative - Other								
Description			Amount					
OUTSOURCING-IT/PAYROLL/TIMECLOCK			\$ 4,891					
MISCELLANEOUS			3,488					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 8,379					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SEE ENCLOSED WORKSHEET	LEGAL FEES		\$ 1,676				Out-of-State Travel	\$
SCHEFFEL BOYLE	ACCOUNTING & AUDITING		4,965					
							In-State Travel	
							Seminar Expense	
							MEETING/SEMINARS/PARKING	370
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,641	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 370

* Attach copy of IMRF notifications

**See instructions.

GROUP HOME 1 (#0036947)
PAGES 3 & 4, SCHEDULE V RECLASSIFICATIONS
JUNE 30, 2018

BANK & BROKER FEES INCLUDED AS INTEREST	6,543	17
	(6,543)	32
CNA TRAINING INCLUDED AS NURSING	4,632	13
	(4,632)	10
DUES & FEES INCLUDED AS TRAVEL AND SEMINAR	57	17
	(57)	24

GROUP HOME 1 (#0036947)
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.
JUNE 30, 2018

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
TRANS MAINT #4-F150	\$ 330	\$ -	\$ -	\$ 330
FORD FOCUS CAR #1	545	-	-	545
IDOT VAN #15	2,218	-	-	2,218
IDOT VAN #16	2,218	-	-	2,218
TRANS. MAINT. #6 -TRUCK	299	-	-	299
MAINT. #8 F350 TRUCK	1,329	-	-	1,329
IDOT BUS-VAN #17	4,384	-	-	4,384
E-350 VAN #18-15 PASS.	1,362	-	-	1,362
E-350 VAN #19-15 PASS.	1,369	-	-	1,369
TRUCK FOR MAINTENANCE	257	-	-	257
WHEELCHAIR STRAPS FOR VAN #17	32	-	-	32
2006 CHRYSLER VAN #21	833	-	-	833
2006 CHRYSLER VAN #10	867	-	-	867
WHEELCHAIR VAN # 20	1,697	-	-	1,697
IDOT VAN-#8	1,835	-	-	1,835
MAINTENANCE TRUCK W/SNOW PLOW	1,670	-	-	1,670
VANS-WHEELCHAIR STRAP	121	-	-	121
TRANSPORTATION VAN	1,804	-	-	1,804
TRANSPORTATION VAN	1,433	-	-	1,433
IDOT VAN	1,628	-	-	1,628
MAINTENANCE - TRUCK	1,703	-	-	1,703
SHOULDER HARNESES	86	-	-	86
IDOT VAN	2,887	-	-	2,887
2010 CHRYSLER	1,574	-	-	1,574
MAINTENANCE TRUCK	276	-	-	276
4X4 CHEVY TRUCK	874	-	-	874
CHEVY C1500 SILVERADO	1,120	-	-	1,120
2008 MERCURY MARINER	861	-	-	861
FORD E250	2,045	-	-	2,045
FLEET REPAIRS	338	-	-	338
DUMP TRUCK REPAIRS	35	2	2	33
VAN SEAT REPAIR	219	22	22	219
VAN	2,844	284	284	2,844
1997 FORD PICKUP	294	59	59	64
MAINT-2010 F150 4X2	755	151	151	252
MAINT-2012 4X4 F-150	755	151	151	252
TRANSPORTATION-VAN #14 LIFT	289	58	58	115
TRANSPORTATION-VAN #6 LIFT	65	13	13	24
TRANSPORTATION-TURTLE TOP BUS	3,322	664	664	1,052
TRANSPORTATION-NEW VAN	1,268	169	169	169
TRANSPORTATION-NEW VAN	2,460	328	328	328
	<u>\$ 50,301</u>	<u>\$ 1,901</u>	<u>\$ 1,901</u>	<u>\$ 43,347</u>

GROUP HOME 1 - (#0036947)
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2018

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
TRANSPORTATION	379	412	\$ 5,963	14.47
SAFETY & SECURITY	104	104	2,605	25.05
	483	516	\$ 8,568	