FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0037614

Facility Name: GROUP HOME #3

Address: 302 BACHMAN (Number) GODFREY (City) 62035 (Zip Code)

County: MADISON

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

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501(c)(3)

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2017 to 6/30/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) BRENDA MILLER

(Title) FINANCE DIRECTOR

Paid Preparer

(Signed) (Date)

(Print Name and Title) DANIEL E. PHIPPS, PRINCIPAL

(Firm Name & Address) SCHEFFEL BOYLE, 106 W. COUNTY ROAD, JERSEYVILLE, IL 62052

(Telephone) (618) 498-6841 Fax # (618) 498-6842

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

Facility Name & ID Number GROUP HOME #3 # 0037614 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		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 Patient Days by Level of Care and Primary Source of Payment: 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	4,880	306		5,186	13
14	TOTALS	4,880	306		5,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.80%

D. How many bed reserve days during this year were paid by the Department?
329 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/20/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/20/1991 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number GROUP HOME #3 # 0037614 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	433	20		453		453		453			1
2	Food Purchase		29,199		29,199		29,199		29,199			2
3	Housekeeping	18,486	3,846		22,332		22,332		22,332			3
4	Laundry											4
5	Heat and Other Utilities			14,365	14,365		14,365		14,365			5
6	Maintenance	19,750	7,274	5,037	32,061		32,061		32,061			6
7	Other (specify):* SECURITY	2,605	9	5,629	8,243		8,243		8,243			7
8	**TOTAL General Services**	41,274	40,348	25,031	106,653		106,653		106,653			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	245,734	2,873		248,607	(7,549)	241,058		241,058			10
10a	Therapy											10a
11	Activities	4,178	767	105	5,050		5,050		5,050			11
12	Social Services											12
13	CNA Training					7,549	7,549		7,549			13
14	Program Transportation	5,963			5,963		5,963		5,963			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	255,875	3,640	105	259,620		259,620		259,620			16
	C. General Administration											
17	Administrative	25,276		8,283	33,559	6,600	40,159		40,159			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	4,537	7,868	49,031		49,031		49,031			21
22	Employee Benefits & Payroll Taxes			64,090	64,090		64,090		64,090			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	4,537	111,140	177,579	6,543	184,122		184,122			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	359,051	48,525	136,276	543,852	6,543	550,395		550,395			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 GROUP HOME #3 #0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			27,143	27,143		27,143		27,143			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**			54,888	54,888	(6,543)	48,345		48,345			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			40,228	40,228		40,228		40,228			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,228	40,228		40,228		40,228			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	359,051	48,525	231,392	638,968		638,968		638,968			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 GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

BHF USE ONLY									
48		49		50		51		52	

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

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

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

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

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

GROUP HOME #3

ID# 0037614

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROUP HOME #3 **#** 0037614 **Report Period Beginning:** 7/1/2017 **Ending:** 6/30/2018

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BEVERLY FARM FOUNDATION	GODFREY			
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #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 [X] NO

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

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

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

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JEFFERY L. ROSIGNOL	BOD						1
2	BRIAN B. BIRNBAUM	BOD						2
3	ROGER W. QUEEN	BOD						3
4	BARRY ALLSWANG	BOD						4
5	EMILY FRIEND	BOD						5
6	NICHOLAS LYNN	BOD						6
7	DONALD J. PEROZZI	BOD						7
8	CHARLENE SPICELAND	BOD						8
9	JIM SPINDEL	BOD						9
10	DAVID F. SWAIN	BOD						10
11	GEORGE M. WALKER	BOD						11
12	PAMELA E. WHISLER	BOD						12
13	TERRY BECKER	BOD						13
14	PATRICIA DOWNEY	BOD						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number GROUP HOME #3 # 0037614 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 [X] NO [ ]

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

Name of Related Organization: BEVERLY FARM FOUNDATION &
Street Address: GROUP HOMES #1, #2, #4, #5, & #6
City / State / Zip Code: GODFREY, IL 62035
Phone Number: (618) 466-0367
Fax Number: (618) 466-3652

	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	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	$ 3,881,876	$	165	$ 64,090	1
2	17-3	OUTSOURCING-IT/PAYROLL	WAGES	10,000	8	159,301		301	4,795	2
3	17-1	ADMINISTRATIVE SALARIES	HOURS	2,080	8	323,107	323,107	104	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	104	36,626	5
6	6-1	MAINTENANCE STAFF	HOURS	2,080	8	394,998	394,998	104	19,750	6
7	7-3	SECURITY/SAFETY	HOURS	2,080	8	112,608		104	5,629	7
8	7-1	SAFETY MANAGER	HOURS	2,080	8	52,097	52,097	104	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	7,274	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	6,400	12
13	6-3	MAINTENANCE-OTHER	HOURS	2,080	8	60,854		104	3,043	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	104	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	104	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		$ 242,712	25

Facility Name & ID Number GROUP HOME #3 # 0037614 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	09/09/13	$ 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	4/21/19	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.)

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 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 #3 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0037614

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 #3 # 0037614 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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	10,000		$ 5,000	1
2					2
3	TOTALS	10,000		$ 5,000	3

Facility Name & ID Number GROUP HOME #3 # 0037614 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1991	$ 315,358	$ 7,884	40	$ 7,884	$	$ 208,924	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1995	188		5			188	9
10	BUILDING IMPROVEMENTS			2002	853		10			853	10
11	BUILDING IMPROVEMENTS			2004	4,447		10			4,447	11
12	BUILDING IMPROVEMENTS			2005	2,451		10			2,451	12
13	BUILDING IMPROVEMENTS			2008	4,613		5			4,613	13
14	BUILDING IMPROVEMENTS			2012	6,644	664	10	664		3,654	14
15	BUILDING IMPROVEMENTS			2013	3,982	796	5	796		3,584	15
16	BUILDING IMPROVEMENTS			2014	23,595	1,243	VAR	1,243		5,595	16
17	FLOORING FOR MEDICAL ROOM			2015	2,228	446	5	446		1,337	17
18	MAINTENANCE FLOORING			2016	5,162	516	10	516		1,204	18
19	PAINT WHOLE BUILDING			2016	6,025	603	10	603		1,406	19
20	RESIDENTIAL DOOR			2017	1,599	160	10	160		174	20
21	BUILDING IMPROVEMENTS-ALLOCATED			1996	55,608	1,389	VAR	1,389		29,890	21
22	BUILDING IMPROVEMENTS-ALLOCATED			1997	860		VAR			860	22
23	BUILDING IMPROVEMENTS-ALLOCATED			1998	941		15			941	23
24	BUILDING IMPROVEMENTS-ALLOCATED			1999	52	3	20	3		48	24
25	BUILDING IMPROVEMENTS-ALLOCATED			2000	27	1	20	1		24	25
26	BUILDING IMPROVEMENTS-ALLOCATED			2004	63		10			63	26
27	BUILDING IMPROVEMENTS-ALLOCATED			2012	239	16	VAR	16		166	27
28	BUILDING IMPROVEMENTS-ALLOCATED			2013	2,785	279	VAR	279		2,297	28
29	BUILDING IMPROVEMENTS-ALLOCATED			2014	885	123	10	123		512	29
30	ADMIN BUILDING-PARKING LOT-ALLOCATED			2015	210	42	5	42		126	30
31	MAINT-SEWER MAIN REPAIR-ALLOCATED			2015	682	68	10	68		204	31
32	MAINT-DOOR AND FRAME-ALLOCATED			2015	91	9	10	9		27	32
33	MAINT-FLOOR COVERINGS-ALLOCATED			2015	43	9	5	9		26	33
34	MAINT-REPLACED SIDEWALKS-ALLOCATED			2015	231	46	5	46		123	34
35	MAINT-REPLACED SPRINKLERS-ALLOCATED			2015	154	31	5	31		93	35
36	MAINT-NEW 42X64 BUILDING-ALLOCATED			2016	2,418	121	20	121		262	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 #3 # 0037614 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	MAINT-AIR CONDITIONER UNITS-ALLOCATED	2016	$ 1,432	$ 143	10	$ 143	$	$ 310	37
38	MAINT-CEILING TILE-ALLOCATED	2016	128	26	5	26		55	38
39	MAINT-CLOSET LOCKS-ALLOCATED	2016	125	25	5	25		54	39
40	MAINT-CORNER GUARDS-ALLOCATED	2016	95	19	5	19		38	40
41	MAINT-DOOR LOCKSETS-ALLOCATED	2016	348	35	10	35		78	41
42	MAINT-NEW FIRE ALARM PANEL-ALLOCATED	2016	268	54	5	54		125	42
43	MAINT-PAINTING-ALLOCATED	2016	301	60	5	60		121	43
44	MAINT-REPLACE FIRE ALARMS-ALLOCATED	2016	824	82	10	82		165	44
45	MAINT-REPLACED SEWER LINES-ALLOCATED	2016	148	15	10	15		36	45
46	MAINT-REPLACED WATER HEATER-ALLOCATED	2016	427	43	10	43		96	46
47	GUARD SHACK- AIR CONDITIONER-ALLOCATED	2017	39	4	10	4		5	47
48	MAINT-STEEL ENTRY DOOR-ALLOCATED	2017	273	27	10	27		27	48
49	MAINT-CONCRETE PAD FOR PROPANE TANK-ALLOCATE	2017	70	7	10	7		9	49
50	MAINT-FIBER OPTIC PROJECT-ALLOCATED	2017	25,643	855	25	855		855	50
51	MAINT-FRONT DOOR-ALLOCATED	2017	289	24	10	24		24	51
52	MAINT-SPRINKLER HEADS-ALLOCATED	2017	185	7	25	7		7	52
53	MAINT-FIRE ALARMS-ALLOCATED	2017	144	9	15	9		9	53
54	MAINT-FIRE SPRINKLER-ALLOCATED	2017	432	13	25	13		13	54
55	ADMIN-FLOORING ENTIRE BUILDING-ALLOCATED	2018	1,954	16	10	16		16	55
56	ADMIN-AIR CONDITIONER COMPUTER ROOM-ALLOCATI	2018	338	17	5	17		17	56
57	MAINT-CONCRETE FLOOR-MAINT SHED-ALLOCATED	2017	550	25	15	25		25	57
58	ADMIN-NEW CONCRETE AT FRONT ENTRANCE-ALLOCAT	2018	270	3	15	3		3	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 476,717	$ 15,958		$ 15,958	$	$ 276,180	70

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

Facility Name & ID Number GROUP HOME #3 # 0037614 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	$ 50,372	$ 7,331	$ 7,331	$	5-10	$ 29,186	71
72	Current Year Purchases	16,642	1,256	1,256		5-10	1,256	72
73	Fully Depreciated Assets	38,535	697	697		5-10	38,535	73
74								74
75	TOTALS	$ 105,549	$ 9,284	$ 9,284	$		$ 68,977	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)	$ 637,567	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,143	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,143	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)	$ 388,504	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 #3 # 0037614 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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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.

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

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

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

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	125	100		225
3	Classroom Wages (a)	864	2,904		3,768
4	Clinical Wages (b)		2,880		2,880
5	In-House Trainer Wages (c)	338	338		676
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 1,327	$ 6,222	$	$ 7,549
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,549			

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	9

(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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 prescrpts							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.

STATE OF ILLINOIS

Facility Name & ID Number GROUP HOME #3 **#** 0037614 **Report Period Beginning:** 7/1/2017 **Ending:** 6/30/2018

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 Operating	2 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)	1,568,130		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)**	$ 1,568,130	$	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	476,717		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	155,850		16
17	Accumulated Depreciation (book methods)	(388,504)		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)**	$ 249,063	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,817,193	$	25

		1 Operating	2 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)**	$ 1,386,944	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,817,193	$	48

***(See instructions.)**

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,332,062	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,332,062	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	54,882	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)**	$ 54,882	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)**	$ 1,386,944	24 *

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

Facility Name & ID Number GROUP HOME #3 # 0037614 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 693,850	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 693,850	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)**	$ 693,850	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	106,653	31
32	Health Care	259,620	32
33	General Administration	184,122	33
	B. Capital Expense		
34	Ownership	48,345	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	40,228	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 638,968	40
41	**Income before Income Taxes (line 30 minus line 40)****	54,882	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 54,882	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 #3 # 0037614 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
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	275	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	48	48	433	9.02	15
16	Dishwashers					16
17	Maintenance Workers	1,342	1,416	19,750	13.95	17
18	Housekeepers	2,054	2,054	18,486	9.00	18
19	Laundry					19
20	Administrator	551	574	18,897	32.92	20
21	Assistant Administrator	104	104	3,429	32.97	21
22	Other Administrative	400	403	6,736	16.71	22
23	Office Manager					23
24	Clerical	1,997	2,266	32,840	14.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,080	2,280	41,036	18.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,375	17,110	204,698	11.96	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	483	516	8,568	16.60	33
34	TOTAL (lines 1 - 33)	25,688	27,046	$ 359,051 *	$ 13.28	34

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

** See instructions.

B. CONSULTANT SERVICES

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

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA WARFORD	EXECUTIVE DIRECTOR	0	$ 4,775
VICKY PALMER-VOGT	EXECUTIVE DIRECTOR	0	5,000
DEBBIE REED	ASSISTANT DIREC	0	3,429
BRENDA MILLER	FINANCIAL COORD.	0	2,951
RACHEL LOLLIS	ADMINISTRATOR	0	7,988
KRYSTAL GRUENFELDER	ADMINISTRATOR	0	1,133
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	$ 4,795
MISCELLANEOUS	3,488
TOTAL (agree to Schedule V, line 17, col. 3)	$ 8,283
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ENCLOSED WORKSHEET	LEGAL FEES	$ 1,676
SCHEFFEL BOYLE	ACCOUNTING & AUDIT	4,965
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 6,641

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,208
Unemployment Compensation Insurance	1,793
FICA Taxes	27,730
Employee Health Insurance	11,235
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	2,222
MISC EMPLOYEE BENEFITS	2,902
TOTAL (agree to Schedule V, line 22, col.8)	$ 64,090

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,078
Health Care Worker Background Check	
(Indicate # of checks performed 2)	447
Patient Background Checks 1	223
DUES/SUBS/LICENSE FEES	259
IHCA DUES	948
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,955

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
MEETINGS/SEMINARS/PARKING	370
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 370

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROUP HOME #3 # 0037614 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSN ($948)**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **40,228**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **92%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **SCHEFFEL BOYLE**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees

GROUP HOME #3 (#0037614)
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	7,549	13
	(7,549)	10
DUES & FEES INCLUDED AS TRAVEL AND SEMINAR	57	17
	(57)	24

GROUP HOME #3 (#0037614)
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 HARNESSES	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
	$ 50,301	$ 1,901	$ 1,901	$ 43,347

GROUP HOME #3 (#0037614)
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2018

	1	2	3	4
SERVICE	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	