

		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><b>I. IDPH License ID Number:</b> <u>0035196</u></p> <p><b>Facility Name:</b> <u>Tibstra House</u></p> <p><b>Address:</b> <u>271 East 161st St</u> <u>South Holland</u> <u>60473</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708) 596-4442</u> Fax # <u>(708) 596-4486</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1/24/90</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> <u>501(c)(3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Goudzwaard</u> <b>Telephone Number:</b> <u>(708) 371-0800</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/17</u> to <u>6/30/18</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Steve Goudzwaard</u> (Title) <u>Director of Finance</u></td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630       </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Steve Goudzwaard</u> (Title) <u>Director of Finance</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )
<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																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )																												

Facility Name & ID Number Tibstra House

# 0035196 Report Period Beginning: 7/1/17 Ending: 6/30/18

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,480			5,480	13
14	TOTALS	5,480			5,480	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.84%**

**D. How many bed reserve days during this year were paid by the Department?**  
360 (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 1/24/1990

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date \_\_\_\_\_ NO

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

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 2018 Fiscal Year: 2018

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

Facility Name & ID Number Tibstra House # 0035196 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	36,227	2,514	3,673	42,414		42,414		42,414		1
2	Food Purchase		47,440		47,440		47,440		47,440		2
3	Housekeeping	26,976	4,601	453	32,030		32,030		32,030		3
4	Laundry		910		910		910		910		4
5	Heat and Other Utilities			8,198	8,198		8,198		8,198		5
6	Maintenance	7,393	1,941	7,776	17,110		17,110		17,110		6
7	Other (specify):* <b>scavenger</b>			1,907	1,907		1,907		1,907		7
8	<b>TOTAL General Services</b>	70,596	57,406	22,007	150,009		150,009		150,009		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	364,937	2,786	567	368,290		368,290		368,290		10
10a	Therapy	3,361	12	35	3,408		3,408		3,408		10a
11	Activities	36,364	4,389		40,753		40,753		40,753		11
12	Social Services	4,982			4,982		4,982		4,982		12
13	CNA Training										13
14	Program Transportation		5,273		5,273		5,273		5,273		14
15	Other (specify):* <b>Program Director</b>	55,638			55,638		55,638		55,638		15
16	<b>TOTAL Health Care and Programs</b>	465,282	12,460	3,902	481,644		481,644		481,644		16
	<b>C. General Administration</b>										
17	Administrative	34,623			34,623		34,623	(1,027)	33,596		17
18	Directors Fees										18
19	Professional Services			7,462	7,462		7,462	(7)	7,455		19
20	Dues, Fees, Subscriptions & Promotions			1,794	1,794		1,794		1,794		20
21	Clerical & General Office Expenses	22,151	2,061	3,648	27,860		27,860	(338)	27,522		21
22	Employee Benefits & Payroll Taxes			138,224	138,224		138,224	(189)	138,035		22
23	Inservice Training & Education			383	383		383		383		23
24	Travel and Seminar			645	645		645	(120)	525		24
25	Other Admin. Staff Transportation			718	718		718		718		25
26	Insurance-Prop.Liab.Malpractice			11,134	11,134		11,134		11,134		26
27	Other (specify):* <b>miscellaneous</b>		499		499		499		499		27
28	<b>TOTAL General Administration</b>	56,774	2,560	164,008	223,342		223,342	(1,681)	221,661		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	592,652	72,426	189,917	854,995		854,995	(1,681)	853,314		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			42,370	42,370		42,370		42,370			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			42,370	42,370		42,370		42,370			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,456	48,456		48,456		48,456			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			48,456	48,456		48,456		48,456			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	592,652	72,426	280,743	945,821		945,821	(1,681)	944,140			45

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



Tibstra House

ID# 0035196

Report Period Beginning: 7/1/17

Ending: 6/30/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Fundraising payroll	\$ (7)	19	1
2	Fundraising Clerical Salaries	(338)	21	2
3	Non Direct Care Seminars	(120)	24	3
4	Fundraising employee payroll taxes	(189)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(654)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tibstra House# 0035196

Report Period Beginning:

7/1/17

Ending:

6/30/18

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	(1,027)	0	0	0	0	0	0	0	0	0	0	(1,027)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7)	0	0	0	0	0	0	0	0	0	0	(7)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(338)	0	0	0	0	0	0	0	0	0	0	(338)	21
22	Employee Benefits & Payroll Taxes	(189)	0	0	0	0	0	0	0	0	0	0	(189)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(120)	0	0	0	0	0	0	0	0	0	0	(120)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(1,681)	0	0	0	0	0	0	0	0	0	0	(1,681)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(1,681)	0	0	0	0	0	0	0	0	0	0	(1,681)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tibstra House

# 0035196

Report Period Beginning:

7/1/17

Ending:

6/30/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,681)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,681)</b>	<b>45</b>



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
Bethshan Association	100%	Bethshan Association I	Palos Heights	Bethshan Foundation	Palos Heights	Charitable Corp

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 Tibstra House # 0035196 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	none								\$		1	
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$			13

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

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

Facility Name & ID Number Tibstra House

# 0035196

Report Period Beginning:

7/1/17

Ending: 6/30/18

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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

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	6	Maintenance	work orders	945	16	\$ 107,333	\$ 104,614	33	\$ 3,748	1
2	17	Administration	# beds	138	16	298,615	298,615	16	34,622	2
3	19	Professional Services	# beds	138	16	52,620		16	6,101	3
4	20	Dues/Fees/Subscriptions	# beds	138	16	10,749		16	1,246	4
5	21	Clerical & General Office	# beds	138	16	210,618	191,052	16	24,419	5
6	22	Workers Comp	budgeted salaries	6,591,876	16	94,289		570,622	8,162	6
7	22	Other Employee Benefits	# beds	138	16	26,852		16	3,113	7
8	23	In Service Training	# beds	138	16	31		16	4	8
9	24	Seminars & Workshop	# beds	138	16	1,183		16	137	9
10	25	Staff Travel	# beds	138	16	6,192		16	718	10
11	26	Liability Insurance	# beds	138	16	47,424		16	5,498	11
12	27	Miscellaneous	# beds	138	16	2,362		16	274	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 858,268	\$ 594,281		\$ 88,042	25

Facility Name & ID Number Tibstra House

# 0035196

Report Period Beginning:

7/1/17

Ending:

6/30/18

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1	none						\$	\$			\$					
2																
3																
4																
5																
	<b>Working Capital</b>															
6																
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$			\$					
	<b>B. Non-Facility Related*</b>															
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$					

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

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

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

Facility Name & ID Number **Tibstra House**

# **0035196**

Report Period Beginning:

**7/1/17**

Ending:

**6/30/18**

**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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			<b>FOR BHF USE ONLY</b>
	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 Tibstra House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035196

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.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 Tibstra House

# 0035196

Report Period Beginning:

7/1/17

Ending:

6/30/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 2,985 B. General Construction Type: Exterior brick Frame wood Number of Stories 1 w/basement

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

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

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

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

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

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

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

If so, please complete the following:

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

Nature of Costs: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>16 bed ICF w/garage</u>	<u>18,000</u>	<u>1989</u>	<u>\$ 25,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>18,000</b>		<b>\$ 25,000</b>	<b>3</b>



**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1990	1990	\$ 408,781	\$ 10,260	40	\$ 10,260	\$	\$ 290,794
5									
6									
7									
8									
	<b>Improvement Type**</b>								
9	Garage		1992	9,830					9,830
10	Landscaping		1990	2,503	63	40	63		1,746
11	Driveway; parking		1990	33,639					33,639
12	Washroom remodeling		1996	20,165					20,165
13	kitchen sink & countertop		2001	2,635					2,635
14	front door installation		2007	1,250	85	15	85		976
15	water heater		2007	5,860					5,860
16	Guardian Elite Generator		2008	17,300	449	10	449		17,300
17	Roof		2008	12,985	653	20	653		6,889
18	siding & fascia		2009	4,500	304	15	304		2,804
19	Lennox Furnace / air conditioner		2010	12,540	841	15	841		7,074
20	Landscaping Edging / Bushes		2010	1,470	150	10	150		1,145
21	backflow valve replacement		2010	4,650	234	20	234		1,801
22	install accessible ceramic tiled showers (2) with plumbing fixtures		2012	10,550	708	15	708		4,416
23	install drywall, floor, ceramic tiled showers (8)		2013	30,905	2,074	15	2,074		11,244
24	kitchen remodel, new cabinets & flooring		2015	29,506	1,967	15	1,967		6,721
25	sprinkler heads installed over front door and in front closet		2015	1,890	126	15	126		378
26	new windows installed on entire building		2016	30,265	2,018	15	2,018		4,540
27	painting entire interior walls		2016	14,392	1,439	10	1,439		3,118
28	sewer repair		2017	3,495	175	20	175		248
29	hot water heater, 50 gal		2017	1,875	187	10	187		234
30									
31									
32									
33									
34									
35									
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 Tibstra House

# 0035196

Report Period Beginning:

7/1/17

Ending:

6/30/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 660,986	\$ 21,733		\$ 21,733	\$	\$ 433,557	70

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

Facility Name & ID Number Tibstra House

# 0035196

Report Period Beginning:

7/1/17

Ending:

6/30/18

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	\$ 38,567	\$ 5,602	\$ 5,602	\$		\$ 15,036	71
72	Current Year Purchases	1,093	87	87			87	72
73	Fully Depreciated Assets	62,371	496	496			62,371	73
74								74
75	TOTALS	\$ 102,031	\$ 6,185	\$ 6,185	\$		\$ 77,494	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	client transportation	Dodge Caravan 2015/Ford Starcraft 14 pas bus 20		\$ 63,893	\$ 12,779	\$ 12,779	\$	5	\$ 20,549	76
77	Exec Dir./Finance Dir.	Toyota Rav4 2015/Honda CRV 2014		5,427	1,085	1,085		5	4,157	77
78	Maintenance	Ford superduty 2011 / Ford F150 2018		5,573	117	117		5	3,346	78
79	Maintenance	Ford F150 pickup	2013	disposed	471	471			disposed	79
80	TOTALS			\$ 74,893	\$ 14,452	\$ 14,452	\$		\$ 28,052	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)	\$ 862,910	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,370	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,370	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)	\$ 539,103	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 Tibstra House

# 0035196

Report Period Beginning: 7/1/17

Ending: 6/30/18

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		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 **6/30/18**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 582,895	\$ 291,467	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	75,012	398,175	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,333	31,250	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 661,240	\$ 720,892	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	1,044,175	13
14	Buildings, at Historical Cost	660,986	7,982,060	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	176,924	2,151,402	16
17	Accumulated Depreciation (book methods)	(539,103)	(5,489,421)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 323,807	\$ 5,688,216	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 985,047	\$ 6,409,108	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 19,857	\$ 115,027	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		620,565	29
30	Accrued Salaries Payable	52,110	410,102	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,504	14,200	31
32	Accrued Real Estate Taxes(Sch.IX-B)		888	32
33	Accrued Interest Payable		12,088	33
34	Deferred Compensation	696	4,539	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 74,167	\$ 1,177,409	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		1,028,508	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,028,508	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 74,167	\$ 2,205,917	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 910,880	\$ 4,203,191	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 985,047	\$ 6,409,108	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>971,940</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>971,940</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(104,736)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(104,736)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<u>Vehicle - Ford/Starcraft bus</u>	43,676	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>43,676</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>910,880</b>	<b>24</b> *

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



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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 838,587	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 838,587	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	gain on disposition of assets	2,498	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,498	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 841,085	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	150,009	31
32	Health Care	481,644	32
33	General Administration	223,342	33
<b>B. Capital Expense</b>			
34	Ownership	42,370	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	48,456	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 945,821	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(104,736)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (104,736)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 838,587	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 838,587	49

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

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

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

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

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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	1,031	1,124	33,628	29.92
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist	76	88	3,361	38.19
8	Rehab/Therapy Aides				8
9	Activity Director	1,955	2,194	36,364	16.57
10	Activity Assistants				10
11	Social Service Workers	111	126	4,982	39.54
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,820	2,086	36,227	17.37
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	284	311	7,393	23.77
18	Housekeepers	1,658	1,914	26,976	14.09
19	Laundry				19
20	Administrator	200	241	17,933	74.41
21	Assistant Administrator				21
22	Other Administrative	371	403	16,690	41.41
23	Office Manager				23
24	Clerical	853	979	22,151	22.63
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,194	2,520	64,344	25.53
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	15,606	17,414	266,965	15.33
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>Program Director</u>	1,503	1,692	55,638	32.88
34	TOTAL (lines 1 - 33)	27,662	31,092	\$ 592,652 *	\$ 19.06

\* 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	57	\$ 3,673	1-3
36	Medical Director	52	3,300	9-3
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	1	35	10a-3
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) <u>Psychiatrist</u>	2	567	10-3
47				47
48				48
49	TOTAL (lines 35 - 48)	112	\$ 7,575	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

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**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	
Joe Lanenga	Executive Director	0	\$ 17,933	Workers' Compensation Insurance	\$ 8,483	IDPH License Fee	\$ 36	
Steve Goudzwaard	Finance Director	0	11,556	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	72	
Julie Sather	Executive Assistant	0	5,134	FICA Taxes	42,055	Health Care Worker Background Check	37	
				Employee Health Insurance	66,053	(Indicate # of checks performed <u>1</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Inst on Public Policy	789	
				Pension	18,076	Employee Professional Fees/Dues	726	
				Employee Benefits	3,368	Sams Club/filing fees/Visa/Alarm fees	134	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 34,623					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
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	
Dreyer Ooms & VanDrunen	audit & accounting	\$ 3,508	personal use of auto (Exec.Dir)		\$ 848	Out-of-State Travel	\$	
Paycor	payroll service provider	313	personal use of auto (Maint.)		697			
Paycom	payroll service provider	2,603	personal use of auto (Fin.Dir)		756			
US Telepunch	payroll attendance	376				In-State Travel		
Open Systems	accounting software maint.	122						
Informability	IT system contractor	125						
Don Moss	Information Srv Provider	278						
CSP	IT consulting	50				Seminar Expense	525	
Ahead	subscription	58						
Holtrop		17						
Dropbox		12						
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)			\$ 7,462			Entertainment Expense	( )	
						(agree to Sch. V,		
						line 24, col. 8)		
						TOTAL	\$ 525	

\* Attach copy of IMRF notifications

\*\*See instructions.

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**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. Institute on Public Policy - \$789
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? n/a
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 323 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,456  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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? n/a Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? no  
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? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Dreyer, Ooms & VanDurnen Ltd
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. n/a  
Attach invoices and a summary of services for all architect and appraisal fees

**Tibstra House**  
**ID # 0035196**  
**Schedule XX (12) Explanation of Salary Allocation**  
**FY2018**

Freya Mars	(Ln 15-1)	Program Director Salary	\$	54,711
	(Ln 10-1)	QIDP Salary	\$	13,678