

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

<p>I. IDPH License ID Number: <u>0027326</u></p> <p>Facility Name: <u>Searles Group Home</u></p> <p>Address: <u>3310 Searles Avenue</u> <u>Rockford</u> <u>61101</u> <small>Number City Zip Code</small></p> <p>County: <u>Winnebago</u></p> <p>Telephone Number: <u>(815) 965-3390</u> Fax # <u>(815) 966-0160</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/18/82</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c)3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: _____ Telephone Number: (_____) _____ Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c)3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/19</u> to <u>6/30/20</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:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Lisa Munson</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (_____) _____</td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lisa Munson</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (_____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c)3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lisa Munson</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (_____) _____							

Facility Name & ID Number Searles Group Home

0027326 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	12	ICF/DD 16 or Less	12	4,392	6
7	12	TOTALS	12	4,392	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	3,374			3,374	13
14	TOTALS	3,374			3,374	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.82%

D. How many bed reserve days during this year were paid by the Department?
49 (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)
N/A

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

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

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 11/18/82

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/11/82 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: 06/30/20 Fiscal Year: 6/30/20

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

Facility Name & ID Number

Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	28,103	2,529	450	31,082		31,082		31,082		1
2	Food Purchase		47,571		47,571		47,571		47,571		2
3	Housekeeping	15,367	2,645		18,012		18,012		18,012		3
4	Laundry										4
5	Heat and Other Utilities			12,995	12,995		12,995		12,995		5
6	Maintenance	15,614	5,974	14,217	35,805		35,805		35,805		6
7	Other (specify):* Maint Fee & Security Mobile Stops			30,294	30,294		30,294	(28,044)	2,250		7
8	TOTAL General Services	59,084	58,719	57,956	175,759		175,759	(28,044)	147,715		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	403,738	1,722	1,752	407,212		407,212		407,212		10
10a	Therapy										10a
11	Activities		3,001		3,001		3,001		3,001		11
12	Social Services	9,741			9,741		9,741		9,741		12
13	CNA Training										13
14	Program Transportation		2,654	2,727	5,381		5,381		5,381		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	413,479	7,377	4,479	425,335		425,335		425,335		16
	C. General Administration										
17	Administrative	12,382			12,382		12,382		12,382		17
18	Directors Fees										18
19	Professional Services			10,402	10,402		10,402	(1,728)	8,674		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	30,310	5,156	8,748	44,214		44,214		44,214		21
22	Employee Benefits & Payroll Taxes			111,354	111,354		111,354		111,354		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			6,474	6,474		6,474		6,474		26
27	Other (specify):* Management Fee			6,048	6,048		6,048	(6,048)			27
28	TOTAL General Administration	42,692	5,156	143,026	190,874		190,874	(7,776)	183,098		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	515,255	71,252	205,461	791,968		791,968	(35,820)	756,148		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

Searles Group Home

#0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			27,898	27,898	964	28,862		28,862			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,285	7,285		7,285	(75)	7,210			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			22,638	22,638		22,638	(22,638)				34
35	Rent-Equipment & Vehicles			1,550	1,550	(562)	988		988			35
36	Other (specify):* Alloc. Maint Bldg			402	402	(402)						36
37	TOTAL Ownership			59,773	59,773		59,773	(22,713)	37,060			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			29,344	29,344		29,344		29,344			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			29,344	29,344		29,344		29,344			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	515,255	71,252	294,578	881,085		881,085	(58,533)	822,552			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(22,638)	34		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	(75)	32		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 Management & Maint & bookkeeping fee	(35,280)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,993)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (57,993)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	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

BHF USE ONLY							
48		49		50		51	
							52

Searles Group Home

ID# 0027326

Report Period Beginning: 7/1/19

Ending: 6/30/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Management Fee	\$ (6,048)	27	1
2	Maintenance Fee	(28,044)	7	2
3	Bookkeeping/Computer Fee	(1,728)	19	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	(35,820)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Searles Group Home# 0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
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):*	(28,044)	0	0	0	0	0	0	0	0	0	0	(28,044)	7
8	TOTAL General Services	(28,044)	0	0	0	0	0	0	0	0	0	0	(28,044)	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	(1,728)	0	0	0	0	0	0	0	0	0	0	(1,728)	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):*	(6,048)	0	0	0	0	0	0	0	0	0	0	(6,048)	27
28	TOTAL General Administration	(7,776)	0	0	0	0	0	0	0	0	0	0	(7,776)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,820)	0	0	0	0	0	0	0	0	0	0	(35,820)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Searles Group Home # 0027326 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	(75)	0	0	0	0	0	0	0	0	0	0	(75)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(22,638)	0	0	0	0	0	0	0	0	0	0	(22,638)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(22,713)	0	0	0	0	0	0	0	0	0	0	(22,713)	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)	(58,533)	0	0	0	0	0	0	0	0	0	0	(58,533)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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

Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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16								16
17								17
18								18
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Searles Group Home # 0027326 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending: 6/30/20

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 Milestone, Inc. - Central Office
 Street Address 4060 McFarland Road
 City / State / Zip Code Rockford, IL 61111
 Phone Number (815) 654-6100
 Fax Number (815) 654-6444

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	1	Dietary Wages	Days	48,545	4	\$ 311,478	\$ 311,478	4,380	\$ 28,103	1
2	1	Dietary Supplies	Days	106,945	33	61,492		4,380	2,518	2
3	2	Food Purchase	Days	106,945	33	1,161,565		4,380	47,573	3
4	3	Housekeeping Wages	Level of Care/Days	124,465	5	218,342	218,342	8,760	15,367	4
5	6	Maintenance Wages	Level of Care/Days	265,355	35	472,972	472,972	8,760	15,614	5
6	21	Clerical Wages	Level of Care/Days	7,905,840	37	759,840	759,840	315,360	30,310	6
7	21	Office Supplies	Level of Care/Days	7,905,840	37	129,269		315,360	5,156	7
8	21	Telephone,internet&cable	Level of Care/Days	7,905,840	37	219,308		315,360	8,748	8
9	22	Fringe Benefits	Wages	19,483,506	41	4,210,650	4,210,650	515,255	111,354	9
10	35	Rent-Computer	Level of Care/Days	7,905,840	37	14,085		315,360	562	10
11	36	Rent Maintenance Building	Level of Care/Days	7,905,840	37	10,071		315,360	402	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,569,072	\$ 5,973,282		\$ 265,707	25

Facility Name & ID Number

Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

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		7	8	9	10						
		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	U.S. Dept. of HUD		X	Mortgage	\$2,520.00	7/6/81	\$ 343,700	\$ 51,176	4/1/22	8.5000	\$ 5,376	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Illinois Bank & Trust		X	Line of Credit			2,500,000		5/28/20	Floating Prime	1,750	6						
7	Illinois Bank & Trust		X	Line of Credit-Vehicles			80,000	64,511	5/11/24	5.5000	159	7						
8												8						
9	TOTAL Facility Related				\$2,520.00		\$ 2,923,700	\$ 115,687			\$ 7,285	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,923,700	\$ 115,687			\$ 7,285	15						

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

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

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

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 2019 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 2020 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:	2015	_____	8
	2016	_____	9
	2017	_____	10
	2018	_____	11
	2019	_____	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$ _____	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Searles Group Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0027326

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 2019 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 2019.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Searles Group Home

0027326 Report Period Beginning:

7/1/19 Ending:

6/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,800 B. General Construction Type: Exterior Brick Frame Number of Stories one

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

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

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

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

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

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [] 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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for index. Row 1: Project, 129,294, 1982, \$ 17,914, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 129,294, (blank), \$ 17,914, 3.

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

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	12	1982	1982	\$ 326,947	\$ 3,114	30	\$ 3,114	\$	\$ 291,139	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Roof		1993	5,025		20			5,025	9
10	Plumbing		1997	4,560		15			4,560	10
11	Smoke Detectors		1997	2,850		15			2,850	11
12	Blacktop		1998	5,188		15			5,188	12
13	Floor Repair		1998	625	25	25	25		545	13
14	Carpet		1998	4,063		7			4,063	14
15	Window Treatments		1998	1,291		10			1,291	15
16	Water Heater		2002	2,789		10			2,789	16
17	Patio Door		2003	2,845		15			2,845	17
18	Carpet		2004	3,101		7			3,101	18
19	Condenser		2004	3,105		10			3,105	19
20	Replacement of doors & windows		2003	30,504	1,220	25	1,220		20,336	20
21	Deck & Railing		2004	9,137	457	20	457		7,348	21
22	Cabinets		2006	4,579	305	15	305		4,376	22
23	Kitchen Remodel		2006	3,170	211	15	211		3,029	23
24	Garage		2006	19,654	786	25	786		11,006	24
25	Air Conditioner		2008	4,920	246	20	246		3,034	25
26	Blacktop		2011	12,631	842	15	842		7,648	26
27	Sprinkler System		2013	4,434	443	10	443		2,919	27
28	Tub & Shower Valve		2013	3,290	329	10	329		2,139	28
29	Sidewalk & Railings		2019	4,781	319	15	319		345	29
30	Siding on Garage		2019	3,750	125	20	125		125	30
31	Water Heater		2020	4,300	71	5	71		71	31
32	Allocated Maintenance Building				402		402			32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

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)	\$ 467,539	\$ 8,895		\$ 8,895	\$	\$ 388,877	70

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

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	\$ 3,198	\$ 320	\$ 320	\$	10 yrs	\$ 1,253	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	43,423				5-15 yrs	43,423	73
74	Computer Expense-Allocated		562	562				74
75	TOTALS	\$ 46,621	\$ 882	\$ 882	\$		\$ 44,676	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2008 Ford Van	2007	\$ 24,811	\$	\$	\$		\$ 24,811	76
77	Patient Care	Vehicle Chair Lift	2008	6,008					6,008	77
78	Patient Care	2017 Ford Transit Connect	2017	29,957	9,986	9,986			28,293	78
79	Patient Care	2018 Ford Transit Connect	2018	27,298	9,099	9,099			18,198	79
80	TOTALS			\$ 88,074	\$ 19,085	\$ 19,085	\$		\$ 77,310	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)	\$ 620,148	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,862	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,862	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)	\$ 510,863	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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? _____

16. Rental Amount for movable equipment: \$ 988 Description: Copier/Fax/Printer YES NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning: 7/1/19

Ending:

6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/20

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 3,107,428	1
2	Cash-Patient Deposits	21,811	647,990	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	85,041	2,027,709	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		13,221	6
7	Other Prepaid Expenses		33,525	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		25,106	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 106,852	\$ 5,854,979	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,914	1,677,335	13
14	Buildings, at Historical Cost	467,539	24,429,444	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	134,695	6,033,268	16
17	Accumulated Depreciation (book methods)	(510,863)	(22,723,015)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,074,037	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		668,502	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 109,285	\$ 11,159,571	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 216,137	\$ 17,014,550	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 263,776	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,811	647,990	28
29	Short-Term Notes Payable		372,947	29
30	Accrued Salaries Payable		1,008,668	30
31	Accrued Taxes Payable (excluding real estate taxes)		379,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)		79	32
33	Accrued Interest Payable		3,085	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Pension, other benefits		199,299	36
37	Intercompany Transactions	1,841,410		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,863,221	\$ 2,875,684	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		199,535	39
40	Mortgage Payable		1,109,250	40
41	Bonds Payable			41
42	Deferred Compensation		658,808	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,967,593	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,863,221	\$ 4,843,277	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,647,084)	\$ 12,171,273	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 216,137	\$ 17,014,550	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,386,465)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,386,465)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(260,619)	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)	\$ (260,619)	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)	\$ (1,647,084)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning: 7/1/19

Ending:

6/30/20

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 495,982	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 495,982	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	65,985	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	22,604	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)	\$ 88,589	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	75	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 75	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Mgmt. & Maint. & book/computer fee	35,820	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35,820	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 620,466	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	175,759	31
32	Health Care	425,335	32
33	General Administration	190,874	33
B. Capital Expense			
34	Ownership	59,773	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	29,344	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 881,085	40
41	Income before Income Taxes (line 30 minus line 40)**	(260,619)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (260,619)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 421,164	44
45	Private Pay - Net Inpatient Revenue	74,818	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)	\$ 495,982	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation. see page 25

*** 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 Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending:

6/30/20

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	685	769	\$ 24,545	\$ 31.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	396	442	9,741	22.04	11
12	Dietician					12
13	Food Service Supervisor	123	146	4,106	28.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,728	1,921	23,997	12.49	15
16	Dishwashers					16
17	Maintenance Workers	810	895	15,614	17.45	17
18	Housekeepers	1,089	1,282	15,367	11.99	18
19	Laundry					19
20	Administrator	93	109	6,348	58.24	20
21	Assistant Administrator					21
22	Other Administrative	80	83	6,034	72.70	22
23	Office Manager	1,072	1,242	30,310	24.40	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,701	3,093	55,644	17.99	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	244,418	26,564	323,549	12.18	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,195	36,546	\$ 515,255 *	\$ 14.10	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	12	\$ 450	1-3	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) <u>Dental</u>	35	1,752	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	47	\$ 2,202		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%		Description			Amount	Description	Amount	
William Grahn	Administrative		\$ 6,348	Workers' Compensation Insurance		\$ 11,003		IDPH License Fee	\$	
Corp. Admin. Salaries	Administrative		6,034	Unemployment Compensation Insurance		125		Advertising: Employee Recruitment		
				FICA Taxes		38,160		Health Care Worker Background Check		
				Employee Health Insurance		56,914		(Indicate # of checks performed _____)		
				Employee Meals				Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*						
				Pension		3,782				
				Employee Physical Exams		450				
				Other Employee Benefits		544				
				Staff Applicant Referral		376				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 12,382	TOTAL (agree to Schedule V, line 22, col.8)			\$ 111,354	TOTAL (agree to Sch. V, line 20, col. 8)		\$
(List each licensed administrator separately.)								Less: Public Relations Expense		(_____)
B. Administrative - Other								Non-allowable advertising		(_____)
	Description		Amount					Yellow page advertising		(_____)
			\$							
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount		Description	Amount	
C. Professional Services						\$		Out-of-State Travel	\$	
Vendor/Payee	Type		Amount							
Wipfli LLP	Audit		\$ 7,976							
Various	Computer/Programmer		2,075							
Wipfli LLP	Pension Plan		279							
Williams & McCarthy	Legal Fees		72					In-State Travel		
	(General Employment Matters)									
								Seminar Expense		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 10,402	TOTAL			\$	Entertainment Expense		(_____)
(For legal fee disclosure, see page 39 of instructions)								(agree to Sch. V, line 24, col. 8)		
								TOTAL	\$	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning:

7/1/19

Ending: 6/30/20

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? n/a
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line _____
- (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. \$ 29,344
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. \$ n/a Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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: WIPFLI LLP
- (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.

SCHEDULE VII-A: BOARD MEMBER LISTING

<u>NAME</u>	<u>TITLE</u>	<u>TYPE OF SERVICE PROVIDED TO FACILITY</u>	<u>OWNERSHIP INTEREST IN</u>
Ronald Alden	Director	Pension Accounting	McGladrey & Pullen
George Bass	Treasurer	Insurance	Country Ins. & Financial Group
Thomas Budd	Director	Financial	Illinois Bank & Trust
Carol Hartline	Director	Legal	Williams & McCarthy
Ben Holmstrom	Chairperson	Construction	William Charles Connstruction
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Vickie Kieffer	Secretary	N/A	
Christine Kinsman	Director	N/A	
Tom Matus	Director	N/A	Mechanical Inc.
Becky Norwood	Director	Insurance	Gallagher Williams-Manny, Inc.
Cyrus Oates	Vice Chairperson	N/A	
Shawn Way	President & CEO	Administrative Services	
Audrey Wickstrand	Director	N/A	

SCHEDULE VII-A: RELATED PARTIES

<u>MILESTONE, INC.</u>	RESIDENTIAL <u>BEDS</u>	<u>CITY</u>	TYPE OF <u>BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	84	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	12	Rockford	ICF/DD<16 & Fewer
Sun Valley	8	Rockford	ICF/DD<16 & Fewer
Applewood	8	Loves Park	C.I.L.A. Services
Orchard	8	Rockford	C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	32	Rockford	Children's Group Home DD
Shattuck	5	Rockford	C.I.L.A. Services
Eggleston	5	Rockford	C.I.L.A. Services
Dierks	8	Rockford	C.I.L.A. Services
Geneva	5	Rockford	C.I.L.A. Services
C.I.L.A.	18	Rockford	C.I.L.A. Services
Windcloud	5	Rockford	C.I.L.A. Services
Prospect	5	Rockford	C.I.L.A. Services
Hanford	5	Rockford	C.I.L.A. Services
Rural	5	Rockford	C.I.L.A. Services
Flintridge	5	Rockford	C.I.L.A. Services
Old Golf	8	Loves Park	C.I.L.A. Services
Creekside	5	Rockford	C.I.L.A. Services
Hermitage	5	Rockford	C.I.L.A. Services
Javelin II	5	Rockford	C.I.L.A. Services
Windpoint	5	Rockford	C.I.L.A. Services
Weymouth	5	Rockford	C.I.L.A. Services
Fleetwood	5	Rockford	C.I.L.A. Services
Stornway	5	Rockford	C.I.L.A. Services
Shiloh	6	Rockford	C.I.L.A. Services
Black Oak	5	Rockford	C.I.L.A. Services
Sawgrass	6	Rockford	C.I.L.A. Services
Crested Butte	6	Rockford	C.I.L.A. Services
Dental Program	N/A	Rockford	Dental Services
Thyme	8	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Apawamis	5	Rockford	C.I.L.A. Services
Southbridge	5	Rockford	C.I.L.A. Services
South Mulford	8	Rockford	C.I.L.A. Services
Commonwealth	8	Rockford	C.I.L.A. Services
HUD Project #071-EH003	N/A	Rockford	Housing
HUD Project #071-EH059	N/A	Rockford	Housing
HUD Project #071-EH178	N/A	Rockford	Housing
HUD Project #071-HD160	N/A	Rockford	Housing
HUD Project #071-HD169	N/A	Rockford	Housing
Bingo	N/A	Rockford	Bingo

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	(\$260,619)
Related Organizations Net Income	1,745,345
Federal Form 990 Net Income	<u><u>\$1,484,726</u></u>

NOTE: The U.S. Department of Housing and Urban Development (HUD) mandates that we maintain a separate general ledger for each project built with their funds. This report consolidates the Searles Program general ledger and the HUD Searles Building general ledger. This consolidation necessitates the following consolidation elimination entries for transactions between the two inter-related entities:

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
3	7	7	Maintenance Fee Expense	(28,044)
3	27	7	Management Fee Expense	(6,048)
3	19	7	Bookkeeping/Computer Fee	(1,728)
19	28	1	Mgmt/Maint/bookkeep Fee Revenue	35,820
4	34	7	Rent Expense - Facility	(22,638)
19	16	1	Rent Revenue - Facility	22,638

In compliance with the instructions, the following revenue items have been offset against expenses:

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
4	32	7	Interest Expense	(75)
19	25	1	Interest Income	75

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE V		
<u>Line #</u>	<u>Title</u>	<u>Amount</u>
30	Depreciation	562.00
35	Equipment Rent	<u>(562.00)</u>
		0 -----

To reclassify rental of Computer from Milestone, Inc. Central Office.

30	Depreciation	402.00
36	Rent-Maintenance Building	<u>(402.00)</u>
		0 -----

To reclassify rental of Maintenance Building from Milestone, Inc. Central Office.
