



Facility Name & ID Number Childrens Habilitation Ctr

# 0018424 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	67	Skilled Pediatric (SNF/PED)	67	24,455	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,455	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	
8	SNF				8
9	SNF/PED	22,509			22,509
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	22,509			22,509

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.04%

D. How many bed-hold days during this year were paid by the Department?

391 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 02/05/1973

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: 12/31 Fiscal Year: 12/31

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

**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	10,287		44,797	55,084		55,084	55,084			1
2	Food Purchase		172,632		172,632		172,632	172,632			2
3	Housekeeping	238,222	33,745	23,332	295,299		295,299	295,299			3
4	Laundry	26,742	1,558		28,300		28,300	28,300			4
5	Heat and Other Utilities			88,427	88,427		88,427	88,427			5
6	Maintenance	98,215		108,643	206,858		206,858	206,858			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	373,466	207,935	265,199	846,600		846,600	846,600			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	3,615,698	520,765	208,458	4,344,921		4,344,921	4,344,921			10
10a	Therapy			44,633	44,633		44,633	44,633			10a
11	Activities										11
12	Social Services	103,347			103,347		103,347	103,347			12
13	CNA Training										13
14	Program Transportation			2,744	2,744		2,744	2,744			14
15	Other (specify):* <b>Education</b>	214,282	1,677	110	216,069		216,069	216,069			15
16	<b>TOTAL Health Care and Programs</b>	3,933,327	522,442	267,945	4,723,714		4,723,714	4,723,714			16
	<b>C. General Administration</b>										
17	Administrative	209,833			209,833		209,833	209,833			17
18	Directors Fees										18
19	Professional Services			442,627	442,627		442,627	(22,323)	420,304		19
20	Dues, Fees, Subscriptions & Promotions			11,886	11,886		11,886	11,886			20
21	Clerical & General Office Expenses	168,231	24,472	64,050	256,753		256,753	(1,281)	255,472		21
22	Employee Benefits & Payroll Taxes			1,145,806	1,145,806		1,145,806	1,145,806			22
23	Inservice Training & Education										23
24	Travel and Seminar			11,029	11,029		11,029	11,029			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,436	64,436		64,436	64,436			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	378,064	24,472	1,739,834	2,142,370		2,142,370	(23,604)	2,118,766		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,684,857	754,849	2,272,978	7,712,684		7,712,684	(23,604)	7,689,080		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 &amp; ID Number

Childrens Habilitation Ctr

#0018424

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

## 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	
	<b>D. Ownership</b>											
30	Depreciation			129,722	129,722		129,722	(4,310)	125,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,831	12,831		12,831	(1,105)	11,726			32
33	Real Estate Taxes			218,664	218,664		218,664		218,664			33
34	Rent-Facility & Grounds			4,596	4,596		4,596		4,596			34
35	Rent-Equipment & Vehicles			2,852	2,852		2,852		2,852			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			368,665	368,665		368,665	(5,415)	363,250			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	958,357	150,284	27,288	1,135,929		1,135,929		1,135,929			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,716	51,716		51,716		51,716			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	958,357	150,284	79,004	1,187,645		1,187,645		1,187,645			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,643,214	905,133	2,720,647	9,268,994		9,268,994	(29,019)	9,239,975			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				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,310)	30		9
10	Interest and Other Investment Income	(1,105)	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	(209)	21		18
19	Entertainment				19
20	Contributions	(450)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,323)	19		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 PAC Dues	(622)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (29,019)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (29,019)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Childrens Habilitation Ctr

ID# 0018424

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	PAC dues	\$ (622)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(622)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Childrens Habilitation Ctr# 0018424

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	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):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</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>8</b>
	<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>	<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>16</b>
	<b>C. General Administration</b>													
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	(22,323)	0	0	0	0	0	0	0	0	0	0	(22,323)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,281)	0	0	0	0	0	0	0	0	0	0	(1,281)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(23,604)</b>	<b>0</b>	<b>(23,604)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(23,604)</b>	<b>0</b>	<b>(23,604)</b>	<b>29</b>									

## STATE OF ILLINOIS

Facility Name & ID Number Childrens Habilitation Ctr# 0018424

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	(4,310)	0	0	0	0	0	0	0	0	0	0	(4,310)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,105)	0	0	0	0	0	0	0	0	0	0	(1,105)	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>(5,415)</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>(5,415)</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>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(29,019)</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>(29,019)</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
See Pg 6 Supp						

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							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.

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	Donald Blivas	21.67	None		None			1
2	Pauline Lightfoot	4.91	None		None			2
3	Stuart J Love	2.57	None		None			3
4	William G. Love Jr.	2.56	None		None			4
5	William G. Love	5.14	None		None			5
6	Carol Rawls	10.27	None		None			6
7	Estate of David Markle	32.34	None		None			7
8	Estate of Lowell Zollar	20.54	None		None			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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

## 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	Pamela Markle	CEO	Administrator	0.00	0	50	100.00	Salary	\$ 157,620	17-1	1
2	Carol Ross	Physical Therapist	Physical Therapy	10.27	0	32	100.00	Hourly	69,689	39-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 227,309		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 Childrens Habilitation Ctr

# 0018424 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Childrens Habilitation Ctr

# 0018424

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

**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**					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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	First Merchants Bank		x	Line of Credit			\$ 1,000,000	\$			\$ 6,068	1					
2	Jules & Associates		x	Chevy 4500 Bus				17,356			1,726	2					
3	Jules & Associates		x	Sprinkler System			80,500	32,642			2,155	3					
4	TCF		x	Medical Equipment				15,332			2,460	4					
5	Phillips		x	Medical Equipment				5,110			422	5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 1,080,500	\$ 70,440			\$ 12,831	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,080,500	\$ 70,440			\$ 12,831	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**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>																																				
1. Real Estate Tax accrual used on 2013 report.		\$ <b>215,008</b>	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.)		\$ <b>210,520</b>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>(4,488)</b>	3																																	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>223,152</b>	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.		\$ <b>218,664</b>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2009</td><td><u>121,613</u></td><td>8</td></tr> <tr><td>2010</td><td><u>127,361</u></td><td>9</td></tr> <tr><td>2011</td><td><u>185,156</u></td><td>10</td></tr> <tr><td>2012</td><td><u>202,838</u></td><td>11</td></tr> <tr><td>2013</td><td><u>210,520</u></td><td>12</td></tr> </table>	2009	<u>121,613</u>	8	2010	<u>127,361</u>	9	2011	<u>185,156</u>	10	2012	<u>202,838</u>	11	2013	<u>210,520</u>	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2013</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2009	<u>121,613</u>	8																																		
2010	<u>127,361</u>	9																																		
2011	<u>185,156</u>	10																																		
2012	<u>202,838</u>	11																																		
2013	<u>210,520</u>	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2013	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
<b>RE Tax accrual computed as \$210,520 (2013 actual) x 6% increase = \$223,152.</b>																																				

**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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Childrens Habilitation Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018424

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 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>29-18-217-044-0000</u>	<u>Long term care property</u>	\$ <u>136.91</u>	\$ <u>136.91</u>
2. <u>29-18-217-045-0000</u>	<u>Long term care property</u>	\$ <u>207,756.28</u>	\$ <u>207,756.28</u>
3. <u>29-18-217-046-0000</u>	<u>Long term care property</u>	\$ <u>2,627.11</u>	\$ <u>2,627.11</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>210,520.30</u></u>	\$ <u><u>210,520.30</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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).

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>46,186</u>	<u>1971</u>	<u>\$ 58,845</u>	1
2					2
3	<b>TOTALS</b>	<b>46,186</b>		<b>\$ 58,845</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	67	1973	1973	\$ 818,025	\$	35	\$	\$	\$ 818,025	4
5		1974	1974	3,368		35			3,368	5
6		1978	1978	1,701		35			1,701	6
7		1979	1979	1,425		35			1,425	7
8		1980	1980	4,255		35			4,255	8
<b>Improvement Type**</b>										
9	Various		1988	4,961	157	20		(157)	4,961	9
10	Various		1989	39,620	1,258	20		(1,258)	39,620	10
11	Various		1990	87,762	2,786	20		(2,786)	87,762	11
12	Various		1991	3,429	109	20		(109)	3,429	12
13	Various		1993	26,119	829	20	829		18,206	13
14	Various		1994	20,166	517	20	517		10,665	14
15	Various		1995	159,072	4,078	20	4,078		78,467	15
16	Various		1996	8,175	210	20	210		3,982	16
17	Various		1997	20,753	532	20	532		9,777	17
18	Various		1998	6,828	175	20	175		2,977	18
19	Various		1999	5,438	139	20	139		2,231	19
20	Various		2000	1,399	36	20	36		538	20
21	Various		2001	9,450	242	39	242		3,392	21
22	Various		2002	2,000	51	39	51		662	22
23	Various		2003	71,216	1,826	39	1,826		20,281	23
24	Various		2005	4,842	65	20	65		2,909	24
25	Various		2007	4,459	446	10	446		3,196	25
26	Various		2008	96,118	2,465	39	2,465		16,328	26
27	Various		2009	14,685	1,468	10	1,468		8,410	27
28	Sprinkler system		2012	80,500	8,050	10	8,050		20,125	28
29	Fire system panel		2012	4,528	453	10	453		1,116	29
30	Conduit Installation		2014	22,850	1,714	10	1,714		1,714	30
31	Generator outlets		2014	8,818	588	10	588		588	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Childrens Habilitation Ctr

# 0018424

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

**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	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,531,962	\$ 28,194		\$ 23,884	\$ (4,310)	\$ 1,170,110	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	\$ 408,469	\$ 61,499	\$ 61,499	\$		\$ 249,774	71
72	Current Year Purchases	196,023	24,850	24,850			24,850	72
73	Fully Depreciated Assets	1,053,083					1,053,083	73
74								74
75	TOTALS	\$ 1,657,575	\$ 86,349	\$ 86,349	\$		\$ 1,327,707	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		Chevy 4500 Bus	2009	\$ 106,252	\$ 15,179	\$ 15,179	\$	7	\$ 77,159	76
77										77
78										78
79										79
80	TOTALS			\$ 106,252	\$ 15,179	\$ 15,179	\$		\$ 77,159	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)	\$ 3,354,634	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 129,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,412	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,310)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,574,976	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 Childrens Habilitation Ctr

# 0018424

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 2,852 Description: Medical equipment and copier

(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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	39 Col 1 & 2	hrs	266,605		1,104	2,499		270,208	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-2	# of prescrpts				42,506		42,506	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Respiratory Therapist</u>	39 Col 1 & 2		691,752		26,184	105,279		823,215	13	
14	TOTAL			\$ 958,357		\$ 27,288	\$ 150,284		\$ 1,135,929	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 Childrens Habilitation Ctr# 0018424Report Period Beginning: 01/01/2014

Ending:

12/31/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(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	\$ 1,383,044	\$	1
2	Cash-Patient Deposits	67,432		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,271,930		3
4	Supply Inventory (priced at )	5,786		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,679		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	7,349		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,748,220	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	58,845		13
14	Buildings, at Historical Cost	1,609,727		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,686,062		16
17	Accumulated Depreciation (book methods)	(2,544,917)		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>	\$ 809,717	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,557,937	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 134,063	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,433		28
29	Short-Term Notes Payable	17,356		29
30	Accrued Salaries Payable	583,523		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)	223,152		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached</u>	27,220		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,092,747	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	77,122		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>	\$ 77,122	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,169,869	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,388,068	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,557,937	\$	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,166,289</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Calculation error - adjusted to agree with audited financial</b>	<b>(3,900)</b>	<b>3</b>
<b>4</b>	<b>statements</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>1,162,389</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,425,679</b>	<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>(200,000)</b>	<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>2,225,679</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,388,068</b>	<b>24</b> *

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

Facility Name & ID Number Childrens Habilitation Ctr# 0018424Report Period Beginning: 01/01/2014Ending: 12/31/2014

**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	\$ 10,117,550	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,117,550	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	92,090	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 92,090	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	1,517,346	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>	\$ 1,517,346	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,600	24
25	Interest and Other Investment Income***	1,105	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,705	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous and Garnishment Income</b>	3,982	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,982	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,734,673	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	846,600	31
32	Health Care	4,723,714	32
33	General Administration	2,142,370	33
<b>B. Capital Expense</b>			
34	Ownership	368,665	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,135,929	35
36	Provider Participation Fee	51,716	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,268,994	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,465,679	41
42	<b>Income Taxes</b>	(40,000)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,425,679	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,117,550	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>	\$ 10,117,550	49

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

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

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

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

Facility Name & ID Number Childrens Habilitation Ctr

# 0018424

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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	1,960	2,080	\$ 85,142	\$ 40.93	1
2	Assistant Director of Nursing	2,206	2,426	82,040	33.82	2
3	Registered Nurses	15,878	17,187	476,123	27.70	3
4	Licensed Practical Nurses	31,071	33,505	848,754	25.33	4
5	CNAs & Orderlies	143,664	157,235	2,021,937	12.86	5
6	CNA Trainees					6
7	Licensed Therapist	33,898	36,985	901,471	24.37	7
8	Rehab/Therapy Aides	3,745	4,265	56,886	13.34	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	4,286	4,690	103,347	22.04	11
12	Dietician	780	816	10,287	12.61	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,649	4,273	98,215	22.99	17
18	Housekeepers	17,749	19,216	238,222	12.40	18
19	Laundry	2,075	2,203	26,742	12.14	19
20	Administrator	2,016	2,080	157,620	75.78	20
21	Assistant Administrator	1,689	1,909	52,213	27.35	21
22	Other Administrative	4,985	5,581	125,497	22.49	22
23	Office Manager	1,848	2,036	42,734	20.99	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction	11,774	14,118	214,282	15.18	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,825	2,069	43,020	20.79	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Nurse Practitioner</u>	1,760	1,760	58,682	33.34	33
34	TOTAL (lines 1 - 33)	286,858	314,434	\$ 5,643,214 *	\$ 17.95	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	896	\$ 44,783	1-3	35
36	Medical Director	150	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	30	1,770	10a-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	84	6,281	10a-3	41
42	Respiratory Therapy Consultant		38,352	10a-3	42
43	Speech Therapy Consultant	445	13,335	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	8	1,200	10-3	45
46	Other(specify)				46
47	<u>Psychologist</u>	117	14,600	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,730	\$ 132,321		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Pamela Markle	CEO	0	\$ 157,620	Workers' Compensation Insurance	\$ 173,354	IDPH License Fee	\$	
Tammy Carter	Asst. Administrator	0	24,836	Unemployment Compensation Insurance	230,601	Advertising: Employee Recruitment	7,200	
Venis Neal	Asst. Administrator	0	27,377	FICA Taxes	419,269	Health Care Worker Background Check		
				Employee Health Insurance	265,320	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Licenses	4,186	
				Pension	53,671	Subscriptions	500	
				Life insurance	3,591			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 209,833			Non-allowable advertising	( )	
						Yellow page advertising	( )	
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	
Frost, Ruttenberg & Roth	Auditing	\$ 26,000			\$	Out-of-State Travel	\$ 4,796	
FGMK, LLC	Accounting services	31,250				See attachment		
Pay Choice	Payroll services	16,670						
Project Leadership Associates	IT services	26,415				In-State Travel	2,973	
Duane Morris LLP	Legal-Health care matters	62,823				See attachment		
Greenberg Traurin, LLP	Legal-LPN labor practices	188,381						
Litchfield Cavo LLP	Legal-Past employee issues	22,323						
Weis, DuBrock, Doody & Maher	Legal-Real Estate Tax issues	6,019				Seminar Expense	3,260	
MPA, Inc,	Consulting	62,746				See attachment		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		Entertainment Expense	( )	
(For legal fee disclosure, see page 39 of instructions)			\$ 442,627		\$	(agree to Sch. V, line 24, col. 8)		
						TOTAL	\$ 11,029	

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	None	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
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17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Childrens Habilitation Ctr# 0018424Report Period Beginning: 01/01/2014 Ending: 12/31/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$3,698
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,331 Line 10
- (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. \$ 51,716  
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
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? Line 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? 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: Frost, Ruttenberg & Rothblatt, P.C.
- (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.