

		FOR BHF USE					

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**2016**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2016)**

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

<p><b>I. IDPH License ID Number:</b> <u>0036749</u></p> <p><b>Facility Name:</b> <u>Aviston Terrace</u></p> <p><b>Address:</b> <u>349 West First St</u> <u>Aviston</u> <u>62216</u>        Number City Zip Code</p> <p><b>County:</b> <u>Clinton</u></p> <p><b>Telephone Number:</b> <u>( 618) 228-7040</u> <b>Fax #</b> <u>( 618) 228-7002</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>01/01/1991</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 C (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>630-361-2868</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 C (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2015</u> to <u>6/30/2016</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%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Lawrence A. Manson</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> 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>Lawrence A. Manson</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

# 0036749 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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	4,498			4,498	13
14	TOTALS	4,498			4,498	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.81%**

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

None (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  Non-allowable costs have been eliminated in Schedule V, Column 7

**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 01/01/1991

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date 01/01/1991 NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

**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	15,718	1,578	1,281	18,577		18,577		18,577		1
2	Food Purchase		23,369		23,369		23,369		23,369		2
3	Housekeeping		1,029		1,029		1,029		1,029		3
4	Laundry		1,666		1,666		1,666		1,666		4
5	Heat and Other Utilities			17,234	17,234		17,234	3	17,237		5
6	Maintenance	10,673	1,294	4,472	16,439		16,439	15	16,454		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	26,391	28,936	22,987	78,314		78,314	18	78,332		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	175,338	4,419	2,111	181,868		181,868		181,868		10
10a	Therapy										10a
11	Activities	53	1,629	176	1,858		1,858		1,858		11
12	Social Services			2,340	2,340		2,340		2,340		12
13	CNA Training										13
14	Program Transportation			2,307	2,307		2,307		2,307		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	175,391	6,048	8,734	190,173		190,173		190,173		16
	<b>C. General Administration</b>										
17	Administrative	7,667		266,374	274,041		274,041	(266,374)	7,667		17
18	Directors Fees							4,390	4,390		18
19	Professional Services			3,052	3,052		3,052	10,551	13,603		19
20	Dues, Fees, Subscriptions & Promotions			1,165	1,165		1,165	2,776	3,941		20
21	Clerical & General Office Expenses	6,673	1,705	10,308	18,686		18,686	70,451	89,137		21
22	Employee Benefits & Payroll Taxes			69,592	69,592		69,592	10,898	80,490		22
23	Inservice Training & Education			179	179		179		179		23
24	Travel and Seminar			853	853		853	1,489	2,342		24
25	Other Admin. Staff Transportation			2,324	2,324		2,324	995	3,319		25
26	Insurance-Prop.Liab.Malpractice			6,604	6,604		6,604	313	6,917		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	14,340	1,705	360,451	376,496		376,496	(164,511)	211,985		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	216,122	36,689	392,172	644,983		644,983	(164,493)	480,490		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Aviston Terrace

#0036749

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

## 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			15,416	15,416		15,416	2,730	18,146			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,977	31,977		31,977	14,343	46,320			32
33	Real Estate Taxes			2	2		2	(2)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,019	2,019			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			47,395	47,395		47,395	19,090	66,485			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,046		2,046		2,046		2,046			39
40	Barber and Beauty Shops			9	9		9		9			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,949	30,949		30,949		30,949			42
43	Other (specify):* <b>Disallowed Costs</b>			1,236	1,236		1,236	(1,236)				43
44	<b>TOTAL Special Cost Centers</b>		2,046	32,194	34,240		34,240	(1,236)	33,004			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	216,122	38,735	471,761	726,618		726,618	(146,639)	579,979			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

**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	211	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,565)	43		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 See Page 5A	(145,285)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (146,639)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (146,639)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Aviston Terrace

ID# 0036749

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Disallowed HO Costs	\$ (145,612)	43	1
2	Day Program Transportation Expense	329	43	2
3	Disallow Real Estate Taxes	(2)	33	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
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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>	(145,285)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc	100	See Pg 6-Supp		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	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	5 Utilities	\$	Progressive Housing, Inc.	100.00%	\$ 3	\$	3	1
2	V	6 Maintenance		Progressive Housing, Inc.	100.00%	15		15	2
3	V	17 Administrative	266,374	Progressive Housing, Inc.	100.00%			(266,374)	3
4	V	18 Director Fees		Progressive Housing, Inc.	100.00%	4,390		4,390	4
5	V	19 Professional Services		Progressive Housing, Inc.	100.00%	10,551		10,551	5
6	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	2,776		2,776	6
7	V	21 Clerical and General Office	14	Progressive Housing, Inc.	100.00%	70,465		70,451	7
8	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	10,898		10,898	8
9	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	1,489		1,489	9
10	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	995		995	10
11	V	26 Insurance		Progressive Housing, Inc.	100.00%	313		313	11
12	V	30 Depreciation		Progressive Housing, Inc.	100.00%	2,519		2,519	12
13	V	32 Interest	54	Progressive Housing, Inc.	100.00%	14,397		14,343	13
14	Total		\$ 266,442			\$ 118,811	\$ *	(147,631)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

**VII. RELATED PARTIES (continued)**

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V							15
16	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	2,019	2,019	16
17	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	145,612	145,612	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$ 147,631	\$ * 147,631	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Aviston Terrace

# 0036749

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

## 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			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Steger	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop	6
7			Terra Estates-closed	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Mt Vernon	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Aviston Terrace

# 0036749

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

## 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	Edward Childers	Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	\$ 569	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,983		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

SEE ACCOUNTANTS' PREPARATION REPORT

Aviston Terrace  
0036749  
6/30/2016

SCHEDULE 7A

BOARD OF DIRECTOR FEES

*Progressive Housing, Inc.*

	<b>Cora Flota</b>	<b>Edward Childers</b>	<b>Edward Copeland</b>	<b>Orland Bauer</b>	<b>Robert Bauer</b>	<b>Shawn Jeffers</b>	<b>Eileen Mullin</b>	<b>Misc Exp</b>	<b>Total</b>
Sparta Terrace	569	569	569	569	569	569	569	405	4,390
Ellner Terrace	569	569	569	569	569	569	569	405	4,390
Taylorville Terrace	569	569	569	569	569	569	569	405	4,390
Aviston Terrace	569	569	569	569	569	569	569	405	4,390
Briarbrook Place	569	569	569	569	569	569	569	405	4,390
Harris Place	569	569	569	569	569	569	569	405	4,390
Joshua Manor	569	569	569	569	569	569	569	405	4,390
Terra Estates								157	157
Park Place	569	569	569	569	569	569	569	405	4,390
Western Gardens	249	249	249	249	249	249	249	(27)	1,713
Galaxy	284	284	284	284	284	284	284	(32)	1,957
Cardinal	284	284	284	284	284	284	284	(32)	1,957
Bill Goat Hill	284	284	284	284	284	284	284	(32)	1,957
Country Club Hill	213	213	213	213	213	213	213	151	1,643
Lee Street	213	213	213	213	213	213	213	151	1,643
Baker Street	213	213	213	213	213	213	213	151	1,643
182nd Street	213	213	213	213	213	213	213	151	1,643
Osage	213	213	213	213	213	213	213	151	1,643
Oakwood	213	213	213	213	213	213	213	151	1,643
Blair	-	-	-	-	-	-	-	318	318
Lowell	249	249	249	249	249	249	249	177	1,917
Marquette	249	249	249	249	249	249	249	177	1,917
Cherry	213	213	213	213	213	213	213	151	1,643
Luella	284	284	284	284	284	284	284	202	2,191
Olivia	249	249	249	249	249	249	249	177	1,917
Huron	213	213	213	213	213	213	213	151	1,643
Wilshire	249	249	249	249	249	249	249	177	1,917
Constance	284	284	284	284	284	284	284	193	2,182
175th Place	249	249	249	249	249	249	249	178	1,918
Sauganash	180	180	180	180	180	180	180	126	1,383
Steger	249	249	249	249	249	249	249	177	1,917
Waltonville	-	-	-	-	-	-	-	244	244
Mt. Vernon	-	-	-	-	-	-	-	388	388
<b>Total BOD Expense</b>	<b>9,600</b>	<b>9,600</b>	<b>9,600</b>	<b>9,600</b>	<b>9,600</b>	<b>9,600</b>	<b>9,600</b>	<b>7,016</b>	<b>74,216</b>

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/2015

Ending: 5/30/2016

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 Progressive Housing, Inc.  
 Street Address 20180 Governors Dr., Suite 300  
 City / State / Zip Code Olympia Fields, IL 60461  
 Phone Number ( 708) 283-1530  
 Fax Number ( 708) 283-2470

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	5	Utilities	Bed Capacity/Specific Alloc.	270	29	47	16	\$ 3	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	270	29	258	16	15	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	270	29	74,216	16	4,390	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	270	29	180,145	16	10,551	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	270	29	49,923	16	2,776	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	270	29	1,229,303	16	70,465	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	270	29	193,338	16	10,898	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	270	29	27,210	16	1,489	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	270	29	17,338	16	995	9
10	26	Insurance	Bed Capacity/Specific Alloc.	270	29	7,498	16	313	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	270	29	43,850	16	2,519	11
12	32	Interest	Bed Capacity/Specific Alloc.	270	29	250,479	16	14,397	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	270	29	41,954	16	2,019	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	270	29	4,719,330	16	145,612	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 6,834,889	\$ 1,076,524	\$ 266,442	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 941,465	\$ 764,464	08/15/26	6.7500	\$ 30,531	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Amortization										1,446	6								
7	Allocation from Home Office-Interest										13,669	7								
8	Allocation from Home Office-Amortization										728	8								
9	<b>TOTAL Facility Related</b>						\$ 941,465	\$ 764,464			\$ 46,374	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12									Interest Income Offset-HO		(54)	12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (54)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 941,465	\$ 764,464			\$ 46,320	15								

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

\*\* 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 2015 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.)	2015	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

  

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2011	_____	8
	2012	_____	9
	2013	_____	10
	2014	_____	11
	2015	_____	12

  

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**N/A - Not for profit entity**

**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.**

SEE ACCOUNTANTS' PREPARATION REPORT

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Aviston Terrace COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036749

CONTACT PERSON REGARDING THIS REPORT Lawrence Manson

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? \_\_\_\_\_ YES 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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 Aviston Terrace

# 0036749 Report Period Beginning:

7/1/2015 Ending:

6/30/2016

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 3,900 B. General Construction Type: Exterior Brick/Siding Frame Wood Number of Stories One

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).

N/A

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>26,400</u>	<u>1991</u>	<u>\$ 20,000</u>	<u>1</u>
2	<u>Allocated from Home Office</u>			<u>6,657</u>	<u>2</u>
3	<b>TOTALS</b>	<b>26,400</b>		<b>\$ 26,657</b>	<b>3</b>

SEE ACCOUNTANTS' PREPARATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1991	1986	\$ 432,500 *	\$ 10,413	40	\$ 10,413	\$	\$ 274,205	4
5			2012	(15,972)					(6,636)	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Expand Bedroom		1991	1,862		15			1,862	9
10	Celing Light Fixtures		1993	536		15			536	10
11	Sprinkler System		1996	936		15			936	11
12	Sprinkler System		1998	1,274		15			1,274	12
13	Bathroom Toilets		2001	1,349		15	45	45	1,349	13
14	Bathroom Tiles		2001	2,720		15	110	110	2,720	14
15	Bathroom Tiles and Drywall		2001	2,540	169	15	169		2,524	15
16	Sprinkler System		2004	4,614	308	15	308		3,873	16
17	Sprinkler System		2004	900	60	15	60		700	17
18	Furanace Upgrade		2005	1,623	108	15	108		1,225	18
19	Ohio Valley Sprinkler Air Compressor		2005	1,994	133	15	133		1,430	19
20	New A/C		2006	1,014	11	15	68	57	684	20
21	Living Room Carpet		2007	1,185	79	15	79		744	21
22	Gazebo		2007	1,796	120	15	120		1,029	22
23	Alarm System Upgrade		2008	1,529	102	15	102		858	23
24	Concrete Sidewalk		2008	2,000	133	15	133		987	24
25	Flooring - Zickel		2010	3,731	249	15	249		1,577	25
26	New Roof (Gross of Write Off of Old Roof-See Line 5)		2012	14,919	995	15	994	(1)	3,728	26
27	Water Heater		2012	4,798	320	15	320		1,154	27
28	Install and paint new steel doors		2014	1,820	121	15	121		223	28
29	New A/C unit		2015	1,692	113	15	113		141	29
30										30
31										31
32	Allocated from Home Office			10,973			450	450		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

SEE ACCOUNTANTS' PREPARATION REPORT

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)	\$	482,333	\$	13,434	\$	14,095	\$	661	\$	297,123	70

SEE ACCOUNTANTS' PREPARATION REPORT

\*\*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	\$ 18,227	\$ 1,970	\$ 1,970	\$	5-10 Yrs	\$ 14,096	71
72	Current Year Purchases	699	12	12		10 Yrs	12	72
73	Fully Depreciated Assets	21,750				5-10 Yrs	21,750	73
74	Allocated from Home Office	21,506		1,687	1,687		16,676	74
75	TOTALS	\$ 62,182	\$ 1,982	\$ 3,669	\$ 1,687		\$ 52,534	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	Facility Use	1998 Astro Van	2004	\$ 4,000	\$	\$	\$	5	\$ 4,000	76
77	Facility Use	Fuel Pump	2008	934				5	934	77
78	Facility Use	2008 Chrysler Van	2008	18,328				5	18,328	78
79	Allocated from Home Office			551		382	382			79
80	TOTALS			\$ 23,813	\$	\$ 382	\$ 382		\$ 23,262	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)	\$ 594,985	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,416	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,146	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,730	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 372,919	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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 N/A.

N/A

N/A

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: \$ 2,019 Description: Allocated from Home Office - postage machine \$88, copier \$1,257, storage \$674

(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	<u>N/A</u>		\$	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

**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 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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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
					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	39(2)	# of prescrpts				2,046		2,046	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	<b>TOTAL</b>			\$		\$	2,046		\$ 2,046	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning: 7/1/2015

Ending:

6/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2016

(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	\$ 62,437	\$ 62,437	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,185 )	66,165	66,165	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,711	5,711	7
8	Accounts Receivable (owners or related parties)	3,023	3,023	8
9	Other(specify): <u>Reserves/Deposits</u>	78,318	78,318	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 215,654	\$ 215,654	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	26,657	13
14	Buildings, at Historical Cost	39,500	482,333	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	42,241	85,995	16
17	Accumulated Depreciation (book methods)	(35,524)	(372,919)	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 (spe <u>Loan Costs</u> )	5,792	5,792	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 72,009	\$ 227,858	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 287,663	\$ 443,512	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 16,810	\$ 16,810	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,501	24,501	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,614	1,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,292	15,292	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	16,939	16,939	36
37	<u>Deposits/Deferred Income</u>	898	898	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 76,054	\$ 76,054	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	764,464	764,464	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Bond Fund</u>	73,513	73,513	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 837,977	\$ 837,977	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 914,031	\$ 914,031	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (626,368)	\$ (470,519)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 287,663	\$ 443,512	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(411,372)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(411,372)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(214,996)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(214,996)</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>(626,368)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 503,381	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 503,381	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,709	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,709	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,383	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,383	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Rental Income</u>	4,149	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,149	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 511,622	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	78,314	31
32	Health Care	190,173	32
33	General Administration	376,496	33
<b>B. Capital Expense</b>			
34	Ownership	47,395	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,291	35
36	Provider Participation Fee	30,949	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 726,618	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(214,996)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (214,996)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 503,381	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>	\$ 503,381	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 19A 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.

SEE ACCOUNTANTS' PREPARATION REPORT

**Aviston Terrace**  
**0036749**  
**6/30/2016**

**SCH 19A**

Schedule XVII  
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)  
and is part of a Consolidated Entity Tax Return.  
Therefore, the Income or Loss cannot be  
traced to the Federal Income Tax Return.

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	288	7,306	22.48	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		53		10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	1,427	15,718	9.86	15
16	Dishwashers				16
17	Maintenance Workers	693	10,673	13.36	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	219	7,667	31.29	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	280	6,673	22.02	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	113	2,450	16.67	28
29	Resident Services Coordinator	828	14,766	16.89	29
30	Habilitation Aides (DD Homes)	13,488	150,816	10.54	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	17,336	216,122 *	11.62	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	24	\$ 1,281	L1, C3 35
36	Medical Director	Monthly	1,800	L9, C3 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	763	L10, C3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	3	176	L11, C3 44
45	Social Service Consultant	43	2,340	L12, C3 45
46	Other(specify) <u>Dental</u>	15	1,348	L10, C3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	85	\$ 7,708	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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' PREPARATION REPORT



