

Facility Name & ID Number Care Center of Abingdon

0047951 Report Period Beginning: 10/1/16 Ending: 9/30/17

III. STATISTICAL DATA

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

	1	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	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	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	9,066	6,029	1,240	16,335	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,066	6,029	1,240	16,335	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.58%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO 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 04/01/06

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 04/01/06 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 82 and days of care provided 847

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/2017 Fiscal Year: 9/30/2017

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0047951 Report Period Beginning: 10/1/16 Ending: 9/30/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	157,575	15,570	6,772	179,917		179,917		179,917		1
2	Food Purchase		157,703		157,703		157,703	(10,659)	147,044		2
3	Housekeeping	82,001	16,489		98,490		98,490		98,490		3
4	Laundry	51,540	9,890		61,430		61,430		61,430		4
5	Heat and Other Utilities			70,678	70,678		70,678		70,678		5
6	Maintenance	39,377	15,188	33,553	88,118		88,118		88,118		6
7	Other (specify):*										7
8	TOTAL General Services	330,493	214,840	111,003	656,336		656,336	(10,659)	645,677		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,107,399	89,694	5,893	1,202,986		1,202,986		1,202,986		10
10a	Therapy										10a
11	Activities	78,237	2,461		80,698		80,698		80,698		11
12	Social Services	7,308			7,308		7,308		7,308		12
13	CNA Training										13
14	Program Transportation			3,123	3,123		3,123		3,123		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,192,944	92,155	24,016	1,309,115		1,309,115		1,309,115		16
	C. General Administration										
17	Administrative	70,788			70,788		70,788		70,788		17
18	Directors Fees							1,785	1,785		18
19	Professional Services			215,059	215,059		215,059	2,331	217,390		19
20	Dues, Fees, Subscriptions & Promotions			11,168	11,168		11,168	(39)	11,129		20
21	Clerical & General Office Expenses	17,384	8,306	44,782	70,472		70,472	40	70,512		21
22	Employee Benefits & Payroll Taxes			236,171	236,171		236,171		236,171		22
23	Inservice Training & Education			2,619	2,619		2,619		2,619		23
24	Travel and Seminar			116	116		116		116		24
25	Other Admin. Staff Transportation			3,124	3,124		3,124		3,124		25
26	Insurance-Prop.Liab.Malpractice			40,584	40,584		40,584		40,584		26
27	Other (specify):*										27
28	TOTAL General Administration	88,172	8,306	553,623	650,101		650,101	4,117	654,218		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,611,609	315,301	688,642	2,615,552		2,615,552	(6,542)	2,609,010		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

Care Center of Abingdon

#0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			28,271	28,271		28,271	36,973	65,244			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			61,200	61,200		61,200		61,200			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			368	368		368		368			35
36	Other (specify):*											36
37	TOTAL Ownership			269,839	269,839		269,839	(143,027)	126,812			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,421	4,421		4,421		4,421			38
39	Ancillary Service Centers		53,473	117,590	171,063		171,063		171,063			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,115	3,115		3,115	(3,115)				41
42	Provider Participation Fee			138,494	138,494		138,494		138,494			42
43	Other (specify):* See Att Sch 4A	33,059		144,969	178,028		178,028	(173,476)	4,552			43
44	TOTAL Special Cost Centers	33,059	53,473	408,589	495,121		495,121	(176,591)	318,530			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,644,668	368,774	1,367,070	3,380,512		3,380,512	(326,160)	3,054,352			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

Care Center of Abingdon

Period Beginning 10/1/16

Period End 9/30/17

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4						
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory/Expenses			4,230	4,230		4,230		4,230		
	Radiology Expenses			322	322		322		322		
	Non-Allowable Expenses	33,059		140,417	173,476		173,476	(173,476)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special C	33,059	0	144,969	178,028	0	178,028	(173,476)	4,552		

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	(10,659)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,803)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		1 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	(540)	20		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	(120,432)	43		24
25	Fund Raising, Advertising and Promotional	(9,182)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		43		28
29	Other-Attach Schedule See Page 5A	(36,174)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (187,789)		\$	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)	(138,371)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (138,371)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (326,160)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Care Center of Abingdon

ID# 0047951

Report Period Beginning: 10/1/16

Ending: 9/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Income Against Vending Expense	\$ (3,115)	41	1
2	Disallow Marketing Wages	(33,059)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(36,174)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,659)	0	0	0	0	0	0	0	0	0	0	(10,659)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,659)	0	0	0	0	0	0	0	0	0	0	(10,659)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	1,785	0	0	0	0	0	0	0	0	0	1,785	18
19	Professional Services	0	2,331	0	0	0	0	0	0	0	0	0	2,331	19
20	Fees, Subscriptions & Promotions	(540)	1	500	0	0	0	0	0	0	0	0	(39)	20
21	Clerical & General Office Expenses	0	40	0	0	0	0	0	0	0	0	0	40	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(540)	4,157	500	0	4,117	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,199)	4,157	500	0	(6,542)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Care Center of Abingdon# 0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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)	
	D. Ownership													
30	Depreciation	1	0	(143,028)	0	0	0	0	0	0	0	0	(143,027)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1	0	(143,028)	0	(143,027)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(3,115)	0	0	0	0	0	0	0	0	0	0	(3,115)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(173,476)	0	0	0	0	0	0	0	0	0	0	(173,476)	43
44	TOTAL Special Cost Centers	(176,591)	0	0	0	0	0	0	0	0	0	0	(176,591)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(187,789)	4,157	(142,528)	0	(326,160)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

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	18 Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 1,785	\$ 1,785	1	
2	V	19 Professional Fees		Unlimited Development, Inc.	100.00%	2,331	2,331	2	
3	V	20 Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	1	1	3	
4	V	21 General Admin Expense		Unlimited Development, Inc.	100.00%	40	40	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		\$			\$ 4,157	\$ *	4,157	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning: 10/1/16

Ending: 9/30/17

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	20 Dues, Fees, Subs & Prom	\$	Abingdon West Martin	N/A	\$ 500	\$	500	15
16	V	30 Depreciation	180,000	Abingdon West Martin	N/A	36,972		(143,028)	16
17	V	34 Facility Rent		Abingdon West Martin	N/A				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	Total		\$ 180,000			\$ 37,472	\$ *	(142,528)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryville				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Care Center of Abingdon	Abingdon				20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCorn	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Marti	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	14
15	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	See Attached Schedule 7A								\$ 1,785	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,785		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

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending: 9/30/17

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 Unlimited Development, Inc.
 Street Address 285 S Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

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	18	Director Fees	Weighted Avail Bed Days 528,155	21	\$ 31,500	\$	29,930	\$ 1,785	1
2	19	Professional Fees	Weighted Avail Bed Days 528,155	21	41,123		29,930	2,331	2
3	20	Dues, Licenses and Subs	Weighted Avail Bed Days 528,155	21	25		29,930	1	3
4	21	General Admin Expense	Weighted Avail Bed Days 528,155	21	703		29,930	40	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	TOTALS				\$ 73,351	\$		\$ 4,157	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2	N/A									2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	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.)

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 2016 report.		\$	44,687	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.)	2016	\$	60,979	2
3. Under or (over) accrual (line 2 minus line 1).		\$	16,292	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	44,908	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	61,200	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	57,358	8
	2013	59,522	9
	2014	60,111	10
	2015	60,525	11
	2016	60,979	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained.

Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.

Taxes paid during year represents the entire 2016 bill.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Care Center of Abingdon COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0047951

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-32-455-017</u>	<u>5.1 A IN SE COR W 1/2 SE S32</u>	\$ <u>60,979.26</u>	\$ <u>60,979.26</u>
2. _____	<u>T10 R1 CITY OF ABINGDON</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>60,979.26</u></u>	\$ <u><u>60,979.26</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,366 B. General Construction Type: Exterior Brick Frame Wood 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

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: N/A
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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 5.85 Acres, 2006, \$ 60,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, #VALUE!, (blank), \$ 60,000, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning:

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Ending:

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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	82	2006		\$ 1,478,900	\$	40	\$ 36,973	\$ 36,973	\$ 428,266	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sidewalk		2007	5,571	371	15	371		3,836	9
10	Handrails, Rewire House, Concrete Ramp		2008	20,621	1,175	15-20 yrs	1,175		10,659	10
11	Furnace and A/C unit		2009	6,145	512	12	512		4,395	11
12	Roof		2011	24,650	2,465	10	2,465		15,817	12
13	Sprinkler		2013	101,155	4,046	25	4,046		16,521	13
14	Vertical Blinds w/ Matching Valances		2013	3,365	673	5	673		2,579	14
15	New AC Units		2014	10,750	2,150	5	2,150		7,167	15
16	Doors		2014	2,577	258	10	258		838	16
17	Bathroom Remodel-Tile/Drains/Fixtures/Paint/Exhaust Fan		2014	22,667	1,889	12	1,889		5,824	17
18	Electrical Circuits/Emergency Generator Shut Off/Pull Station		2016	5,900	1,180	5	1,180		1,770	18
19	Retube Boiler w/ Stainless Steel Tubes		2016	8,750	438	20	438		474	19
20	Replaced Water Heater-Boiler Room		2016	4,075	340	10	340		340	20
21	Replaced Water Heater-Boiler Room		2017	13,781	919	10	919		919	21
22	TV Cable Wiring		2017	7,215	481	5	481		481	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

*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

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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)	\$ 1,716,122	\$ 16,897		\$ 53,870	\$ 36,973	\$ 499,886	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning:

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Ending:

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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	\$ 316,358	\$ 11,374	\$ 11,374	\$	5-15 yrs	\$ 266,740	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 316,358	\$ 11,374	\$ 11,374	\$		\$ 266,740	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,092,480	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,271	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,244	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 36,973	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 766,626	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

9. Option to Buy: YES NO Terms: N/A *

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: \$ 368 Description: See Attached Schedule 14A

(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	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Care Center of Abingdon
IDPH License ID Number: 0047951
Fiscal Year End: 9/30/17

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	227
Office Equipment	141
Other Equipment Rental	
Total - Line 16	368

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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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				
1	Licensed Occupational Therapist	39(3)	hrs	\$	110	\$ 45,807	\$	110	\$ 45,807	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		19	8,310		19	8,310	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		132	57,505		132	57,505	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 prescripts				53,473		53,473	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)			57	5,613		57	5,613	12
13	Other (specify): <u>Miscellaneous</u>	39(3)				355			355	13
14	TOTAL			\$	318	\$ 117,590	\$ 53,473	318	\$ 171,063	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 Care Center of Abingdon

0047951

Report Period Beginning: 10/1/16

Ending: 9/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 62,799	\$ 83,517	1
2	Cash-Patient Deposits	18,312	18,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 210,000)	699,540	699,540	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,391	50,391	6
7	Other Prepaid Expenses	2,980	2,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		344,734	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 834,022	\$ 1,199,474	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost	237,223	1,716,122	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	155,258	316,358	16
17	Accumulated Depreciation (book methods)	(177,254)	(766,626)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 215,227	\$ 1,325,854	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,049,249	\$ 2,525,328	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 40,380	\$ 40,380	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,312	18,312	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,537	30,537	30
31	Accrued Taxes Payable (excluding real estate taxes)	43,432	43,432	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,908	44,908	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	3,937,531	3,937,531	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,115,100	\$ 4,115,100	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	6,000	6,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,000	\$ 6,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,121,100	\$ 4,121,100	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,071,851)	\$ (1,595,772)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,049,249	\$ 2,525,328	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,250,473)	1
2	Restatements (describe):		2
3	Prior Year Post Closing Adjustment	(3,564)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,254,037)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(817,814)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (817,814)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,071,851)	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,546,348	1
2	Discounts and Allowances for all Levels	(60,902)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,485,446	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	48,408	6
7	Oxygen	710	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 49,118	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,583	12
13	Barber and Beauty Care	2,101	13
14	Non-Patient Meals	10,659	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	2,188	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,531	23
D. Non-Operating Revenue			
24	Contributions	713	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 713	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees	(110)	28
28a	Gain on Disposal	9,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,890	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,562,698	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	656,336	31
32	Health Care	1,309,115	32
33	General Administration	650,101	33
B. Capital Expense			
34	Ownership	269,839	34
C. Ancillary Expense			
35	Special Cost Centers	356,627	35
36	Provider Participation Fee	138,494	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,380,512	40
41	Income before Income Taxes (line 30 minus line 40)**	(817,814)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (817,814)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,137,513	44
45	Private Pay - Net Inpatient Revenue	600,062	45
46	Medicare - Net Inpatient Revenue	337,281	46
47	Other-(specify) Medicare Replacement/Managed Care	135,298	47
48	Other-(specify) Hospice	275,292	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,485,446	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Care Center of Abingdon

0047951

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	1,988	2,097	\$ 62,233	\$ 29.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,518	8,908	138,680	15.57	3
4	Licensed Practical Nurses	15,445	16,482	308,264	18.70	4
5	CNAs & Orderlies	57,082	60,159	565,718	9.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,371	6,784	78,237	11.53	10
11	Social Service Workers	497	609	7,308	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,019	19,091	157,575	8.25	15
16	Dishwashers					16
17	Maintenance Workers	2,328	2,408	39,377	16.35	17
18	Housekeepers	8,940	9,546	82,001	8.59	18
19	Laundry	5,209	5,505	51,540	9.36	19
20	Administrator	1,884	2,081	70,788	34.01	20
21	Assistant Administrator					21
22	Other Administrative	1,952	2,064	33,059	16.02	22
23	Office Manager					23
24	Clerical	1,538	1,647	17,384	10.56	24
25	Vocational Instruction					25
26	Academic Instruction					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	1,992	2,100	32,504	15.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,763	139,480	\$ 1,644,668 *	\$ 11.79	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	Monthly	\$ 6,772	L1, C3	35
36	Medical Director	Monthly	15,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,839	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,611		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

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	
Janet Holmberg	Administrator	None	\$ 49,496	Workers' Compensation Insurance	\$ 27,144	IDPH License Fee	\$ 1,990	
Shannon Mullin	Administrator	None	21,292	Unemployment Compensation Insurance	13,013	Advertising: Employee Recruitment	834	
				FICA Taxes	124,490	Health Care Worker Background Check (Indicate # of checks performed <u>26</u>)	658	
				Employee Health Insurance	63,992	Patient Background Checks <u>41</u>	1,030	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				401k	4,200	Subscriptions	743	
				Other Employee Benefits	3,332	IHCA Dues	5,412	
						Other Licenses & Fees	501	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,788			Allocation of Home Office	1	
B. Administrative - Other						Less: Public Relations Expense	(40)	
Description			Amount			Non-allowable advertising	()	
N/A			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 236,171	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,129	
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
LTC Support Services, LLC	Support Services		\$ 118,800				Out-of-State Travel	\$
RFMS, Inc.	Administrative Services		72,600					
Templin Healthcare Accounting	Accounting Services		3,231	N/A			In-State Travel	116
RSM US LLP	Accounting Services		20,428					
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 215,059	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
							TOTAL	\$ 116

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

