## I. IDPH License ID Number:

### Facility Name:
- Adloff Place

### Address:
- 50 Adloff Lane, Springfield 62703

### County:
- Sangamon

### Telephone Number:
- 217-786-3109

### HFS ID Number:

### Date of Initial License for Current Owners:
- 9/22/1992

### Type of Ownership:
- X VOLUNTARY,NON-PROFIT
- X Charitable Corp.
- IRS Exemption Code: 501c3

## II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2018 to 12/31/2018, 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

### (Signed) ____________

### Type or Print Name: Dan Scott

### (Date) ____________

### (Title) Chief Financial Officer

### (Signed) ____________

### (Date) ____________

### (Print Name) Michael Wills

### (Title) Controller

### (Firm Name) DDMS

### (Address) 468 Halle Park Dr., Collierville, TN 38017

### (Telephone) 901-692-5555

### Email Address: michael.wills@ddms.com
### III. STATISTICAL DATA

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

<table>
<thead>
<tr>
<th>Beds at Beginning of Report Period</th>
<th>Licensure Level of Care</th>
<th>Beds at End of Report Period</th>
<th>Licensed Bed Days During Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Skilled (SNF)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Skilled Pediatric (SNF/PED)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Intermediate (ICF)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Intermediate/DD</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Sheltered Care (SC)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>ICF/DD 16 or Less</td>
<td>16</td>
<td>5,840 6</td>
</tr>
<tr>
<td>7</td>
<td>TOTALS</td>
<td>16</td>
<td>5,840 7</td>
</tr>
</tbody>
</table>

B. Census-For the entire report period.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Patient Days by Level of Care and Primary Source of Payment</th>
<th>Medicaid Recipient</th>
<th>Private Pay</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 SNF</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9 SNF/PED</td>
<td>9</td>
<td>9</td>
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<td></td>
</tr>
<tr>
<td>10 ICF</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 ICF/DD</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 SC</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 DD 16 OR LESS</td>
<td>5,410</td>
<td>5,410</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>14 TOTALS</td>
<td>5,410</td>
<td>5,410</td>
<td></td>
<td></td>
<td>14</td>
</tr>
</tbody>
</table>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.64%
### V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Costs Per General Ledger</th>
<th>Reclassification</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
</tr>
<tr>
<td>A. General Services</td>
<td>34,674</td>
<td>5,248</td>
<td>1,245</td>
</tr>
<tr>
<td>1 Dietary</td>
<td>34,674</td>
<td>5,248</td>
<td>1,245</td>
</tr>
<tr>
<td>2 Food Purchase</td>
<td>38,097</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Housekeeping</td>
<td>7,532</td>
<td>7,532</td>
<td></td>
</tr>
<tr>
<td>4 Laundry</td>
<td>879</td>
<td>879</td>
<td></td>
</tr>
<tr>
<td>5 Heat and Other Utilities</td>
<td>17,777</td>
<td>17,777</td>
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</tr>
<tr>
<td>6 Maintenance</td>
<td>13,480</td>
<td>31,465</td>
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</tr>
<tr>
<td>7 Other (specify):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8 TOTAL General Services</td>
<td>48,154</td>
<td>43,345</td>
<td>45,418</td>
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<tr>
<td>B. Health Care and Programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Medical Director</td>
<td>2,266</td>
<td>2,266</td>
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<tr>
<td>10 Nursing and Medical Records</td>
<td>42,499</td>
<td>16,723</td>
<td>59,222</td>
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<tr>
<td>10a Therapy</td>
<td>321,125</td>
<td>5,029</td>
<td>326,154</td>
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<tr>
<td>11 Activities</td>
<td>176,191</td>
<td>176,191</td>
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</tr>
<tr>
<td>12 Social Services</td>
<td>52</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>13 CNA Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Program Transportation</td>
<td>2,188</td>
<td>2,188</td>
<td></td>
</tr>
<tr>
<td>15 Other (specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 TOTAL Health Care and Programs</td>
<td>363,624</td>
<td>202,449</td>
<td>566,073</td>
</tr>
<tr>
<td>C. General Administration</td>
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<tr>
<td>17 Administrative</td>
<td>30,035</td>
<td>30,035</td>
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</tr>
<tr>
<td>18 Directors Fees</td>
<td>2,400</td>
<td>2,400</td>
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<tr>
<td>19 Professional Services</td>
<td>68,095</td>
<td>68,095</td>
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<tr>
<td>20 Dues, Fees, Subscriptions &amp; Promotions</td>
<td>5,286</td>
<td>5,286</td>
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<tr>
<td>21 Clerical &amp; General Office Expenses</td>
<td>14,439</td>
<td>18,100</td>
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<tr>
<td>22 Employee Benefits &amp; Payroll Taxes</td>
<td>69,847</td>
<td>69,847</td>
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<tr>
<td>23 Inservice Training &amp; Education</td>
<td>1,022</td>
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<tr>
<td>24 Travel and Seminar</td>
<td>7,332</td>
<td>7,332</td>
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<tr>
<td>25 Other Admin. Staff Transportation</td>
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<td></td>
<td></td>
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<tr>
<td>26 Insurance-Prop.Liab.Malpractice</td>
<td>18,582</td>
<td>18,582</td>
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<tr>
<td>27 Other (specify):</td>
<td></td>
<td></td>
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<tr>
<td>28 TOTAL General Administration</td>
<td>30,035</td>
<td>3,661</td>
<td>187,003</td>
</tr>
<tr>
<td>29 TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</td>
<td>441,813</td>
<td>47,006</td>
<td>434,870</td>
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</table>
## V. COST CENTER EXPENSES (continued)

<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>Cost Per General Ledger</th>
<th>Reclassification</th>
<th>Adjustments</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
<td>Total</td>
<td></td>
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<tr>
<td>30 Depreciation</td>
<td>21,374</td>
<td>21,374</td>
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<td>21,374</td>
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<tr>
<td>31 Amortization of Pre-Op. &amp; Org.</td>
<td></td>
<td></td>
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<tr>
<td>32 Interest</td>
<td>5,683</td>
<td>5,683</td>
<td>5,683</td>
<td>(5,107)</td>
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<tr>
<td>33 Real Estate Taxes</td>
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<td></td>
<td></td>
<td>576</td>
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<tr>
<td>34 Rent-Facility &amp; Grounds</td>
<td>3,151</td>
<td>3,151</td>
<td>3,151</td>
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<tr>
<td>35 Rent-Equipment &amp; Vehicles</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>36 Other (specify):**</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
<td>(25,000)</td>
</tr>
<tr>
<td>37 TOTAL Ownership</td>
<td>55,208</td>
<td>55,208</td>
<td>55,208</td>
<td>(30,107)</td>
</tr>
</tbody>
</table>

### Ancillary Expense

<table>
<thead>
<tr>
<th>E. Special Cost Centers</th>
<th>Cost Per General Ledger</th>
<th>Reclassification</th>
<th>Adjustments</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary Transportation</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ancillary Service Centers</td>
<td>1,227</td>
<td>1,227</td>
<td>1,227</td>
<td></td>
</tr>
<tr>
<td>Barber and Beauty Shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee and Gift Shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Participation Fee</td>
<td>49,912</td>
<td>49,912</td>
<td>427</td>
<td>50,339</td>
</tr>
<tr>
<td>Presc Drugs/Penalties</td>
<td>358</td>
<td>358</td>
<td>5,410</td>
<td>5,768</td>
</tr>
<tr>
<td>Other (specify):**</td>
<td>57,334</td>
<td>(358)</td>
<td>56,976</td>
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<tr>
<td>TOTAL Special Cost Centers</td>
<td>51,497</td>
<td>51,497</td>
<td>5,837</td>
<td>57,334</td>
</tr>
</tbody>
</table>

### Grand Total Cost

| GRAND TOTAL COST (sum of lines 29, 37 & 44) | 441,813 | 47,006 | 541,575 | 1,030,394 | 1,030,394 | 998,759 |

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

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

<table>
<thead>
<tr>
<th>NON-ALLOWABLE EXPENSES</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day Care</td>
<td></td>
<td>$ 112</td>
<td></td>
</tr>
<tr>
<td>2 Other Care for Outpatients</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Governmental Sponsored Special Programs</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 Non-Patient Meals</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5 Telephone, TV &amp; Radio in Resident Rooms</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6 Rented Facility Space</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7 Sale of Supplies to Non-Patients</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8 Laundry for Non-Patients</td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9 Non-Straightline Depreciation</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10 Interest and Other Investment Income</td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11 Discounts, Allowances, Rebates &amp; Refunds</td>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12 Non-Working Officer's or Owner's Salary</td>
<td></td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13 Sales Tax</td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14 Non-Care Related Interest</td>
<td>14</td>
<td>(5,107)</td>
<td></td>
</tr>
<tr>
<td>15 Non-Care Related Owner's Transactions</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Personal Expenses (Including Transportation)</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Non-Care Related Fees</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Fines and Penalties</td>
<td>18</td>
<td>(358)</td>
<td>43</td>
</tr>
<tr>
<td>19 Entertainment</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Contributions</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Owner or Key-Man Insurance</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Special Legal Fees &amp; Legal Retainers</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Malpractice Insurance for Individuals</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Bad Debt</td>
<td>24</td>
<td>(25,000)</td>
<td>36</td>
</tr>
<tr>
<td>25 Fund Raising, Advertising and Promotional</td>
<td>25</td>
<td>(1,170)</td>
<td>20</td>
</tr>
<tr>
<td>26 Income Taxes and Illinois Personal Property Replacement Tax</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 CNA Training for Non-Employees</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Yellow Page Advertising</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Other-Attach Schedule</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 SUBTOTAL (A): (Sum of lines 1-29)</td>
<td>30</td>
<td>(31,635)</td>
<td></td>
</tr>
</tbody>
</table>

**BHF USE ONLY**

| 48 | 49 | 50 | 51 | 52 |

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

<table>
<thead>
<tr>
<th>31</th>
<th>32</th>
<th>33</th>
<th>34</th>
<th>35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Paid Workers-Attach Schedule*</td>
<td>Donated Goods-Attach Schedule*</td>
<td>Amortization of Organization &amp; Pre-Operating Expense</td>
<td>Adjustments for Related Organization Costs (Schedule VII)</td>
<td>Other-Attach Schedule</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>38</th>
<th>39</th>
<th>40</th>
<th>41</th>
<th>42</th>
<th>43</th>
<th>44</th>
<th>45</th>
<th>46</th>
<th>47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary Transport.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gift and Coffee Shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Barber and Beauty Shops</td>
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</tr>
<tr>
<td>Laboratory and Radiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Other-Attach Schedule</td>
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**HFS 3745 (N-4-99) IL478-2471**
<table>
<thead>
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<th>Sch. V Line</th>
<th>NON-ALLOWABLE EXPENSES</th>
<th>Amount</th>
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**STATE OF ILLINOIS**

**Facility Name & ID Number**: Adloff Place

**#**: 0038463  
**Report Period Beginning**: 01/01/2018  
**Ending**: 12/31/2018

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

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<th>PAGE 6E</th>
<th>PAGE 6F</th>
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## STATE OF ILLINOIS

**Summary B**

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<th>Ending: 12/31/2018</th>
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**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

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<td>0</td>
<td>44</td>
</tr>
<tr>
<td>45 GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</td>
<td>(31,635)</td>
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</tbody>
</table>

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HFS 3745 (N-4-99)  
IL478-2471
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.

<table>
<thead>
<tr>
<th>OWNERS</th>
<th>RELATED NURSING HOMES</th>
<th>OTHER RELATED BUSINESS ENTITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Ownership %</td>
<td>Name</td>
</tr>
<tr>
<td>Home and Environments for Living and Programs, Inc.</td>
<td></td>
<td>Piasa Manor</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>1 Schedule V Line</th>
<th>2 Item</th>
<th>3 Cost Per General Ledger</th>
<th>4 Amount</th>
<th>5 Cost to Related Organization</th>
<th>6 Percent of Ownership</th>
<th>7 Operating Cost of Related Organization</th>
<th>8 Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 V</td>
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</table>

* Total must agree with the amount recorded on line 34 of Schedule VI.
### VII. RELATED PARTIES

#### A. (Continued)

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

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<tr>
<th>1</th>
<th>OWNERS</th>
<th>Ownership %</th>
<th>Name</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>RELATED NURSING HOMES</td>
<td>City</td>
<td>Name</td>
<td>City</td>
</tr>
<tr>
<td>3</td>
<td>OTHER RELATED BUSINESS ENTITIES</td>
<td>Type of Business</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>Name</th>
<th>Ownership %</th>
<th>Name</th>
<th>City</th>
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</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Ownership Interest</th>
<th>Compensation Received From Other Nursing Homes*</th>
<th>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week</th>
<th>Compensation Included in Costs for this Reporting Period**</th>
<th>Schedule V, Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Paul Dillon</td>
<td>Board of Directors</td>
<td></td>
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<td>1</td>
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<tr>
<td>2 Jon Albright</td>
<td>Board of Directors</td>
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<td>2</td>
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<tr>
<td>3 Mike Worsham</td>
<td>Board of Directors</td>
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<td>TOTAL.</td>
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</tr>
</tbody>
</table>

* 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 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**
### 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.

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Item</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Units</th>
<th>Allocation (col 8/col 4) x col 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>See central office allocation</td>
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<td>2</td>
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<td>worksheet included in the HELP workpapers 12.31.18</td>
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<td>spreadsheet</td>
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<tr>
<td>4</td>
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<td>All costs have been directly reported in the appropriate cost centers</td>
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</table>

**TOTALS:** $2 $2 $25
### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment Required</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate</th>
<th>Reporting Period Interest Expense</th>
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<tr>
<td>B. Non-Facility Related*</td>
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<td>TOTAL Non-Facility Related</td>
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<tr>
<td>15</td>
<td>TOTALS (line 9+line14)</td>
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<td>$</td>
<td>$</td>
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<td>15</td>
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</tbody>
</table>

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)
**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

### B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Real Estate Tax accrual used on 2017 report.</td>
<td>$1</td>
</tr>
<tr>
<td>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.)</td>
<td>$2</td>
</tr>
<tr>
<td>3. Under or (over) accrual (line 2 minus line 1).</td>
<td>$3</td>
</tr>
<tr>
<td>4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)</td>
<td>$4</td>
</tr>
<tr>
<td>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.)</td>
<td>$5</td>
</tr>
<tr>
<td>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.)</td>
<td>$6</td>
</tr>
<tr>
<td>7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.</td>
<td>$7</td>
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</table>

### Real Estate Tax History:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>8</td>
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<tr>
<td>2014</td>
<td>9</td>
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<tr>
<td>2015</td>
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<td>2016</td>
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<td>2017</td>
<td>12</td>
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<table>
<thead>
<tr>
<th></th>
<th>FOR BHF USE ONLY</th>
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<tr>
<td>13</td>
<td>FROM R. E. TAX STATEMENT FOR 2017 $13</td>
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<tr>
<td>14</td>
<td>PLUS APPEAL COST FROM LINE 5 $14</td>
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<tr>
<td>15</td>
<td>LESS REFUND FROM LINE 6 $15</td>
</tr>
<tr>
<td>16</td>
<td>AMOUNT TO USE FOR RATE CALCULATION $16</td>
</tr>
</tbody>
</table>

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

<table>
<thead>
<tr>
<th>(A)</th>
<th>(B)</th>
<th>(C)</th>
<th>(D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Index Number</td>
<td>Property Description</td>
<td>Total Tax</td>
<td>Tax Applicable to Nursing Home</td>
</tr>
<tr>
<td>1. NA - tax exempt</td>
<td></td>
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<td>$</td>
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<td>2.</td>
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</tbody>
</table>

**TOTALS** $ $

### Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.

(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

### Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

STATE OF ILLINOIS  

Report Period Beginning: 01/01/2018  
Ending: 12/31/2018  

Facility Name & ID Number  Adloff Place  

X. BUILDING AND GENERAL INFORMATION:  

A. Square Feet: 4,484  
B. General Construction Type:  
   Exterior: Brick  
   Frame: Wood  
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).  

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

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:  

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>A. Land.</td>
<td>Use</td>
<td>Square Feet</td>
<td>Year Acquired</td>
<td>Cost</td>
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<td>Facility</td>
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<td>1992</td>
<td>50,000</td>
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<td>3</td>
<td>TOTALS</td>
<td>4,484</td>
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<td>50,000</td>
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HFS 3745 (N-4-99)  

IL478-2471
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Beds</th>
<th>FOR BHF USE ONLY</th>
<th>Year Acquired</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
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<tr>
<td>4</td>
<td>16</td>
<td>1992</td>
<td>1992</td>
<td>$494,135</td>
<td>$14,906</td>
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**Improvement Type**

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</thead>
<tbody>
<tr>
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<td>Drywall and Tile for 2 showers</td>
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<td>2,900</td>
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<tr>
<td>15</td>
<td>Sprinkler system</td>
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<td>Sprinkler head replacement</td>
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<td>Kitchen Cabinets</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
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</thead>
<tbody>
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<td>37</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>67</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>68</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>69</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70 TOTAL (lines 4 thru 69)</td>
<td></td>
<td>$28,898</td>
<td>$20,700</td>
<td>$20,700</td>
<td>$</td>
<td>$411,414</td>
</tr>
</tbody>
</table>

**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.)

<table>
<thead>
<tr>
<th>Category of Equipment</th>
<th>1 Current Book Cost</th>
<th>2 Straight Line Depreciation</th>
<th>4 Adjustments</th>
<th>5 Component Life</th>
<th>6 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased in Prior Years</td>
<td>$31,929</td>
<td>$674</td>
<td></td>
<td></td>
<td>$27,795</td>
</tr>
<tr>
<td>Current Year Purchases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Depreciated Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$27,795</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>$31,929</td>
<td>$674</td>
<td>$674</td>
<td></td>
<td>$27,795</td>
</tr>
</tbody>
</table>

#### D. Vehicle Costs. (See instructions.)*

<table>
<thead>
<tr>
<th>1 Use</th>
<th>2 Model, Make and Year</th>
<th>3 Year Acquired</th>
<th>4 Cost</th>
<th>5 Current Book Depreciation</th>
<th>6 Straight Line Depreciation</th>
<th>7 Adjustments</th>
<th>8 Life in Years</th>
<th>9 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client transportation</td>
<td>2006 Ford Van</td>
<td>2006</td>
<td>$33,913</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>$33,913</td>
</tr>
<tr>
<td>Client transportation</td>
<td>2011 Ford Van</td>
<td>2011</td>
<td>26,078</td>
<td></td>
<td></td>
<td>4</td>
<td>26,078</td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td></td>
<td></td>
<td>$59,991</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$59,991</td>
</tr>
</tbody>
</table>

#### E. Summary of Care-Related Assets

<table>
<thead>
<tr>
<th>Description</th>
<th>1 Reference</th>
<th>2 Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Historical Cost</td>
<td>(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)</td>
<td>$670,818</td>
</tr>
<tr>
<td>Current Book Depreciation</td>
<td>(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)</td>
<td>$21,374</td>
</tr>
<tr>
<td>Straight Line Depreciation</td>
<td>(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)</td>
<td>$21,374 **</td>
</tr>
<tr>
<td>Adjustments</td>
<td>(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)</td>
<td>$84</td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
<td>(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)</td>
<td>$499,200</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1 Description &amp; Year Acquired</th>
<th>2 Cost</th>
<th>3 Current Book Depreciation</th>
<th>4 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>87</td>
<td></td>
<td>$</td>
<td>86</td>
</tr>
<tr>
<td>88</td>
<td></td>
<td>$</td>
<td>87</td>
</tr>
<tr>
<td>89</td>
<td></td>
<td>$</td>
<td>88</td>
</tr>
<tr>
<td>90</td>
<td></td>
<td>$</td>
<td>89</td>
</tr>
<tr>
<td>91</td>
<td><strong>TOTALS</strong></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

#### G. Construction-in-Progress

<table>
<thead>
<tr>
<th>Description</th>
<th>1 Reference</th>
<th>2 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>92</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>93</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>94</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>95</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

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

** This must agree with Schedule V line 30, column 8.
### XII. RENTAL COSTS

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

1. Name of Party Holding Lease: Landmark Real Estate (allocation of central office rental)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
   YES  NO

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Building:</td>
<td>9/1/2007</td>
<td>$3,151</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>TOTAL</td>
<td>3,151</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

10. Effective dates of current rental agreement:
   - Beginning 9/1/2007
   - Ending

11. Rent to be paid in future years under the current rental agreement:
   - Fiscal Year Ending 2019 $ 
   - 2020 $ 
   - 2021 $ 

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? YES X NO

16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use</td>
<td>Model Year and Make</td>
<td>Monthly Lease Payment</td>
<td>Rental Expense for this Period</td>
</tr>
<tr>
<td>17</td>
<td>$</td>
<td>$</td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$</td>
<td>21</td>
</tr>
</tbody>
</table>

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

** This amount plus any amortization of lease expense must agree with page 4, line 34.
A. TYPE OF TRAINING PROGRAM (IF CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

3. CLINICAL PORTION:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-HOUSE PROGRAM</td>
<td>IN OTHER FACILITY</td>
<td>COMMUNITY COLLEGE</td>
</tr>
<tr>
<td>HOURS PER CNA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. EXPENSES

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

(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.

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETE</td>
<td>TOTAL TRAINED</td>
</tr>
<tr>
<td>1. From this facility</td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td>DROP-OUTS</td>
</tr>
<tr>
<td>1. From this facility</td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td>TOTAL TRAINED</td>
</tr>
</tbody>
</table>

HFS 3745 (N-4-99) IL478-2471
**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

<table>
<thead>
<tr>
<th>Schedule V Line &amp; Column Reference</th>
<th>Service Description</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
<th>Column 6</th>
<th>Column 7</th>
<th>Column 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Licensed Occupational Therapist hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Licensed Speech and Language Development Therapist hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Licensed Recreational Therapist hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Licensed Physical Therapist hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Physician Care visits</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dental Care visits</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Work Related Program hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Habilitation hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Pharmacy # of prescrpts</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Psychological Services (Evaluation and Diagnosis/ Behavior Modification) hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Academic Education hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Other (specify):</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Other (specify):</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>TOTAL</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>1 Operating</th>
<th>2 After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Cash on Hand and in Banks</td>
<td>$ 403</td>
</tr>
<tr>
<td>2</td>
<td>Cash-Patient Deposits</td>
<td>14,321</td>
</tr>
<tr>
<td>3</td>
<td>Accounts &amp; Short-Term Notes Receivable-Patients (less allowance)</td>
<td>184,600</td>
</tr>
<tr>
<td>4</td>
<td>Supply Inventory (priced at)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Short-Term Investments</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Prepaid Insurance</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Other Prepaid Expenses</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Accounts Receivable (owners or related parties)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other(specify):</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Current Assets (sum of lines 1 thru 9)</strong></td>
<td>$ 199,324</td>
<td>$ 617,739</td>
</tr>
</tbody>
</table>

| **B. Long-Term Assets** | | |
| 10 | | |
| **TOTAL Long-Term Assets (sum of lines 11 thru 23)** | | |
| 24 | TOTAL Long-Term Assets (sum of lines 1 thru 23) | $ 171,743 | $ 603,146 |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | $ 371,067 | $ 1,220,885 |

<table>
<thead>
<tr>
<th></th>
<th>1 Operating</th>
<th>2 After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C. Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Accounts Payable</td>
<td>$ 116,435</td>
</tr>
<tr>
<td>27</td>
<td>Officer's Accounts Payable</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Accounts Payable-Patient Deposits</td>
<td>14,321</td>
</tr>
<tr>
<td>29</td>
<td>Short-Term Notes Payable</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Accrued Salaries Payable</td>
<td>92,450</td>
</tr>
<tr>
<td>31</td>
<td>Accrued Taxes Payable (excluding real estate taxes)</td>
<td>12,832</td>
</tr>
<tr>
<td>32</td>
<td>Accrued Real Estate Taxes(Sch.IX-B)</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Accrued Interest Payable</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Deferred Compensation</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Federal and State Income Taxes</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Current Liabilities (sum of lines 26 thru 37)</strong></td>
<td>$ 189,364</td>
<td>$ 420,581</td>
</tr>
</tbody>
</table>

| **D. Long-Term Liabilities** | | |
| 38 | TOTAL Long-Term Liabilities (sum of lines 38 thru 44) | $ (797,788) | $ 383,500 |
| 39 | Long-Term Notes Payable | | |
| 40 | Mortgage Payable | 19,640 | |
| 41 | Bonds Payable | | |
| 42 | Deferred Compensation | | |
| **TOTAL Long-Term Liabilities and Equity (sum of lines 45 thru 47) | | |
| 48 | TOTAL LIABILITIES AND EQUITY | $ 979,491 | $ 397,164 |

***(See instructions.***

---

HFS 3745 (N-4-99)  
HFS 3745 (N-4-99)
### XVI. STATEMENT OF CHANGES IN EQUITY

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Balance at Beginning of Year, as Previously Reported</td>
<td>$944,246</td>
</tr>
<tr>
<td>2</td>
<td>Restatements (describe):</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Balance at Beginning of Year, as Restated (sum of lines 1-5)</td>
<td>$944,246</td>
</tr>
</tbody>
</table>

#### A. Additions (deductions):

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>NET Income (Loss) (from page 19, line 43)</td>
<td>$35,245</td>
</tr>
<tr>
<td>8</td>
<td>Acquisitions of Pooled Companies</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Proceeds from Sale of Stock</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Stock Options Exercised</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Contributions and Grants</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Expenditures for Specific Purposes</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Dividends Paid or Other Distributions to Owners</td>
<td>(       )</td>
</tr>
<tr>
<td>14</td>
<td>Donated Property, Plant, and Equipment</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>TOTAL Additions (deductions) (sum of lines 7-16)</td>
<td>$35,245</td>
</tr>
</tbody>
</table>

#### B. Transfers (Itemize):

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>TOTAL Transfers (sum of lines 18-22)</td>
<td>$979,491</td>
</tr>
<tr>
<td>24</td>
<td>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</td>
<td>$979,491</td>
</tr>
</tbody>
</table>

* This must agree with page 17, line 47.
## Income Statement

**Facility Name & ID Number**: Adloff Place # 0038463  
**Report Period Beginning**: 01/01/2018  
**Ending**: 12/31/2018

### 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 expenses.

<table>
<thead>
<tr>
<th></th>
<th>I. Revenue Amount</th>
<th></th>
<th>II. Expenses Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>A. Inpatient Care</strong></td>
<td></td>
<td><strong>A. Operating Expenses</strong></td>
</tr>
<tr>
<td></td>
<td>1 Gross Revenue -- All Levels of Care <strong>$ 1,034,004</strong></td>
<td>1</td>
<td>31 General Services <strong>$ 136,917</strong></td>
</tr>
<tr>
<td></td>
<td>2 Discounts and Allowances for all Levels ( ) <strong>$ ( )</strong></td>
<td>2</td>
<td>32 Health Care <strong>$ 560,236</strong></td>
</tr>
<tr>
<td></td>
<td><strong>3 TOTAL Inpatient Care (line 1 minus line 2) $ 1,034,004</strong></td>
<td>3</td>
<td>33 General Administration <strong>$ 219,529</strong></td>
</tr>
<tr>
<td></td>
<td><strong>B. Ancillary Revenue</strong></td>
<td></td>
<td><strong>B. Capital Expense</strong></td>
</tr>
<tr>
<td></td>
<td>4 Day Care <strong>$ 4</strong></td>
<td>4</td>
<td><strong>B. Capital Expense</strong></td>
</tr>
<tr>
<td></td>
<td>5 Other Care for Outpatients <strong>$ 5</strong></td>
<td>5</td>
<td><strong>34 Ownership</strong> <strong>$ 25,101</strong></td>
</tr>
<tr>
<td></td>
<td>6 Therapy <strong>$ 6</strong></td>
<td>6</td>
<td><strong>C. Ancillary Expense</strong></td>
</tr>
<tr>
<td></td>
<td>7 Oxygen <strong>$ 7</strong></td>
<td>7</td>
<td><strong>35 Special Cost Centers</strong> <strong>$ 6,637</strong></td>
</tr>
<tr>
<td></td>
<td><strong>8 TOTAL Ancillary Revenue (lines 4 thru 7) $ 8</strong></td>
<td>8</td>
<td><strong>36 Provider Participation Fee</strong> <strong>$ 50,339</strong></td>
</tr>
<tr>
<td></td>
<td><strong>C. Other Operating Revenue</strong></td>
<td></td>
<td><strong>D. Other Expenses (specify):</strong></td>
</tr>
<tr>
<td></td>
<td>9 Payments for Education <strong>$ 9</strong></td>
<td>9</td>
<td><strong>37</strong></td>
</tr>
<tr>
<td></td>
<td>10 Other Government Grants <strong>$ 10</strong></td>
<td>10</td>
<td><strong>38</strong></td>
</tr>
<tr>
<td></td>
<td>11 CNA Training Reimbursements <strong>$ 11</strong></td>
<td>11</td>
<td><strong>39</strong></td>
</tr>
<tr>
<td></td>
<td>12 Grill and Coffee Shop <strong>$ 12</strong></td>
<td>12</td>
<td><strong>40 TOTAL EXPENSES (sum of lines 31 thru 39)</strong> <strong>$ 998,759</strong></td>
</tr>
<tr>
<td></td>
<td>13 Barber and Beauty Care <strong>$ 13</strong></td>
<td>13</td>
<td><strong>41 Income before Income Taxes (line 30 minus line 40)</strong> <strong>$ 35,245</strong></td>
</tr>
<tr>
<td></td>
<td>14 Non-Patient Meals <strong>$ 14</strong></td>
<td>14</td>
<td><strong>42 Income Taxes</strong> <strong>$ 42</strong></td>
</tr>
<tr>
<td></td>
<td>15 Telephone, Television and Radio <strong>$ 15</strong></td>
<td>15</td>
<td><strong>43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</strong> <strong>$ 35,245</strong></td>
</tr>
<tr>
<td></td>
<td>16 Rental of Facility Space <strong>$ 16</strong></td>
<td>16</td>
<td><strong>44 Medicaid - Net Inpatient Revenue</strong> <strong>$ 1,034,004</strong></td>
</tr>
<tr>
<td></td>
<td>17 Sale of Drugs <strong>$ 17</strong></td>
<td>17</td>
<td><strong>45 Private Pay - Net Inpatient Revenue</strong> <strong>$ 45</strong></td>
</tr>
<tr>
<td></td>
<td>18 Sale of Supplies to Non-Patients <strong>$ 18</strong></td>
<td>18</td>
<td><strong>46 Medicare - Net Inpatient Revenue</strong> <strong>$ 46</strong></td>
</tr>
<tr>
<td></td>
<td>19 Laboratory <strong>$ 19</strong></td>
<td>19</td>
<td><strong>47 Other-specify</strong> <strong>$ 47</strong></td>
</tr>
<tr>
<td></td>
<td>20 Radiology and X-Ray <strong>$ 20</strong></td>
<td>20</td>
<td><strong>48 Other-specify</strong> <strong>$ 48</strong></td>
</tr>
<tr>
<td></td>
<td>21 Other Medical Services <strong>$ 21</strong></td>
<td>21</td>
<td><strong>49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)</strong> <strong>$ 1,034,004</strong></td>
</tr>
<tr>
<td></td>
<td>22 Laundry <strong>$ 22</strong></td>
<td>22</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td><strong>23 TOTAL Other Operating Revenue (lines 9 thru 22) $ 23</strong></td>
<td>23</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td><strong>D. Non-Operating Revenue</strong></td>
<td></td>
<td><strong>Other Revenue (specify):</strong>**</td>
</tr>
<tr>
<td></td>
<td>24 Contributions <strong>$ 24</strong></td>
<td>24</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td>25 Interest and Other Investment Income*** <strong>$ 25</strong></td>
<td>25</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td><strong>26 TOTAL Non-Operating Revenue (lines 24 and 25) $ 26</strong></td>
<td>26</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td><strong>E. Other Revenue (specify):</strong>****</td>
<td></td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td>27 Settlement Income (Insurance, Legal, Etc.) <strong>$ 27</strong></td>
<td>27</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td>28 <strong>$ 28</strong></td>
<td>28</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td>28a <strong>$ 28a</strong></td>
<td>28a</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td><strong>29 TOTAL Other Revenue (lines 27, 28 and 28a) $ 29</strong></td>
<td>29</td>
<td><strong>49</strong></td>
</tr>
<tr>
<td></td>
<td><strong>30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) $ 1,034,004</strong></td>
<td>30</td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

---

* This must agree with page 4, line 45, column 4.  
** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.  
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.  
**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.
### XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

<table>
<thead>
<tr>
<th>#</th>
<th>Director of Nursing</th>
<th># of Hrs. Actually Worked</th>
<th># of Hrs. Paid and Accrued</th>
<th>Reporting Period Total Salaries, Wages</th>
<th>Average Hourly Wage</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Assistant Director of Nursing</td>
<td>2</td>
<td>28</td>
<td>30</td>
<td>112.77</td>
</tr>
<tr>
<td>3</td>
<td>Registered Nurses</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>4</td>
<td>Licensed Practical Nurses</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>5</td>
<td>CNAs &amp; Orderlies</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>6</td>
<td>CNA Trainees</td>
<td>28</td>
<td>30</td>
<td>32</td>
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</tr>
<tr>
<td>7</td>
<td>Licensed Therapist</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>8</td>
<td>Rehab Therapy Aides</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>9</td>
<td>Activity Director</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>10</td>
<td>Activity Assistants</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>11</td>
<td>Social Service Workers</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>12</td>
<td>Dietician</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>13</td>
<td>Food Service Supervisor</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>14</td>
<td>Head Cook</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>15</td>
<td>Cook Helpers/Assistants</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>16</td>
<td>Dishwashers</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>17</td>
<td>Maintenance Workers</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>18</td>
<td>Housekeepers</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>19</td>
<td>Laundry</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>20</td>
<td>Administrator</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>21</td>
<td>Assistant Administrator</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>22</td>
<td>Other Administrative</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>23</td>
<td>Office Manager</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>24</td>
<td>Clerical</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>25</td>
<td>Vocational Instruction</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>26</td>
<td>Academic Instruction</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>27</td>
<td>Medical Director</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>28</td>
<td>Qualified MR Prof. (QMRP)</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>29</td>
<td>Resident Services Coordinator</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>30</td>
<td>Habilitation Aides (DD Homes)</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
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<tr>
<td>31</td>
<td>Medical Records</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>32</td>
<td>Other Health Care(specify)</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>33</td>
<td>Other(specify)</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
<tr>
<td>34</td>
<td>TOTAL (lines 1 - 33)</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>112.77</td>
</tr>
</tbody>
</table>

### B. CONSULTANT SERVICES

<table>
<thead>
<tr>
<th>#</th>
<th>Number of Hrs. Paid &amp; Accrued</th>
<th>Total Consultant Cost for Reporting Period</th>
<th>Schedule V Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>Dietary Consultant</td>
<td>$ 1,245</td>
<td>1-3</td>
</tr>
<tr>
<td>36</td>
<td>Medical Director</td>
<td>$ 1,425</td>
<td>9-3</td>
</tr>
<tr>
<td>37</td>
<td>Medical Records Consultant</td>
<td>$ 38</td>
<td>37</td>
</tr>
<tr>
<td>38</td>
<td>Nurse Consultant</td>
<td>$ 38</td>
<td>38</td>
</tr>
<tr>
<td>39</td>
<td>Pharmacist Consultant</td>
<td>$ 39</td>
<td>39</td>
</tr>
<tr>
<td>40</td>
<td>Physical Therapy Consultant</td>
<td>$ 40</td>
<td>40</td>
</tr>
<tr>
<td>41</td>
<td>Occupational Therapy Consultant</td>
<td>$ 41</td>
<td>41</td>
</tr>
<tr>
<td>42</td>
<td>Respiratory Therapy Consultant</td>
<td>$ 42</td>
<td>42</td>
</tr>
<tr>
<td>43</td>
<td>Speech Therapy Consultant</td>
<td>$ 43</td>
<td>43</td>
</tr>
<tr>
<td>44</td>
<td>Activity Consultant</td>
<td>$ 44</td>
<td>44</td>
</tr>
<tr>
<td>45</td>
<td>Social Service Consultant</td>
<td>$ 760</td>
<td>12-3</td>
</tr>
<tr>
<td>46</td>
<td>Other(specify) Dentist</td>
<td>$ 938</td>
<td>10a-3</td>
</tr>
<tr>
<td>47</td>
<td>Radiology</td>
<td>$ 240</td>
<td>10a-3</td>
</tr>
<tr>
<td>48</td>
<td>Eyecare</td>
<td>$ 130</td>
<td>10a-3</td>
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<tr>
<td>49</td>
<td>TOTAL (lines 35 - 48)</td>
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### C. CONTRACT NURSES

<table>
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<tr>
<th>#</th>
<th>Number of Hrs. Paid &amp; Accrued</th>
<th>Total Contract Wages</th>
<th>Schedule V Line &amp; Column Reference</th>
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</thead>
<tbody>
<tr>
<td>50</td>
<td>Registered Nurses</td>
<td>$ 50</td>
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<tr>
<td>51</td>
<td>Licensed Practical Nurses</td>
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<td>51</td>
</tr>
<tr>
<td>52</td>
<td>Certified Nurse Assistants/Aides</td>
<td>$ 52</td>
<td>52</td>
</tr>
<tr>
<td>53</td>
<td>TOTAL (lines 50 - 52)</td>
<td>$ 96</td>
<td>96</td>
</tr>
</tbody>
</table>

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

** See instructions.
### STATE OF ILLINOIS

#### A. Administrative Salaries

<table>
<thead>
<tr>
<th>Name</th>
<th>Function</th>
<th>%</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Admin-Salary-Administrator</td>
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<td></td>
<td>$21,261</td>
</tr>
<tr>
<td>Admin-Salary-Acct. Director</td>
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<td>$8,774</td>
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</table>

#### D. Employee Benefits and Payroll Taxes

<table>
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<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Workers' Compensation Insurance</td>
<td>$35,056</td>
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<tr>
<td>Unemployment Compensation Insurance</td>
<td>$76</td>
</tr>
<tr>
<td>FICA Taxes</td>
<td>$31,711</td>
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<tr>
<td>Employee Health Insurance</td>
<td>$3,005</td>
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<tr>
<td>Employee Meals</td>
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</tr>
<tr>
<td>Illinois Municipal Retirement Fund (IMRF)*</td>
<td>$30,035</td>
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#### B. Administrative - Other

<table>
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<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less: Public Relations Expense</td>
<td></td>
</tr>
<tr>
<td>Non-allowable advertising</td>
<td></td>
</tr>
<tr>
<td>Yellow page advertising</td>
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</table>

#### TOTAL (agree to Schedule V, line 17, col. 1)

<table>
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<tr>
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<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (agree to Schedule V,</td>
<td>$69,848</td>
</tr>
</tbody>
</table>

#### TOTAL (agree to Schedule V, line 17, col. 3)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (agree to Sch. V,</td>
<td>$8,436</td>
</tr>
</tbody>
</table>

#### C. Professional Services

<table>
<thead>
<tr>
<th>Vendor/Payee</th>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris, Shelton</td>
<td>legal</td>
<td>$10</td>
</tr>
<tr>
<td>Watkins Ulberal, PLLC</td>
<td>audit</td>
<td>$5,321</td>
</tr>
<tr>
<td>DDMS</td>
<td>payroll processing</td>
<td>$699</td>
</tr>
<tr>
<td>DDMS, LLC</td>
<td>Mgmt fees</td>
<td>$62,065</td>
</tr>
</tbody>
</table>

#### E. Schedule of Non-Cash Compensation Paid to Owners or Employees

<table>
<thead>
<tr>
<th>Vendor/Payee</th>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### G. Schedule of Travel and Seminar**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-State Travel</td>
<td></td>
</tr>
<tr>
<td>In-State Travel</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>$1,719</td>
</tr>
<tr>
<td>Administrative</td>
<td>$5,613</td>
</tr>
<tr>
<td>Entertainment Expense</td>
<td></td>
</tr>
</tbody>
</table>

#### TOTAL (agree to Schedule V, line 19, column 3)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (agree to Sch. V,</td>
<td>$7,332</td>
</tr>
</tbody>
</table>

---

* Attach copy of IMRF notifications
** See instructions.
XX. GENERAL INFORMATION:

(1) Are nursing employees (RN, LPN, NA) represented by a union? no

(2) Are there any dues to nursing home associations included on the cost report? yes

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? $880

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? 

(5) Have you properly capitalized all major repairs and equipment purchases? yes What was the average life used for new equipment added during this period? 3-15 years

(6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. $0 Line __________

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 49,912 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? no Indicate the amount. $ 

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? no If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $ 

c. What percent of all travel expense relates to transportation of nurses and patients? 90
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no Indicate the amount of income earned from providing such transportation during this reporting period. $ 

(17) Has an audit been performed by an independent certified public accounting firm? yes Firm Name: Watkins Uiberall

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. n/a

HFS 3745 (N-4-99) IL478-2471