FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0005462

Facility Name: The Arthur Home

Address: 423 Eberhardt Drive (Number) Arthur (City) 61911 (Zip Code)

County: Moultrie

Telephone Number: 217-543-2103 **Fax #** 217-543-2278

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1958

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Eversole **Telephone Number:** 217-543-2103
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2009 to 8/31/2010 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.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) David Eversole
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Allan B. Larson, CPA, Principal
(Firm Name & Address) LarsonAllen LLP, 600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4379 Fax # 314-925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	61	23,823	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	60	TOTALS	61	23,823	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,590	8,983	3,288	19,861	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,590	8,983	3,288	19,861	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.37%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/1/1958

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 61 and days of care provided 3,288

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 8/31/2010 Fiscal Year: 8/31/2010

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	246,119	9,488	8,393	264,000		264,000	(1,255)	262,745			1
2	Food Purchase		136,061		136,061		136,061	(5,463)	130,598			2
3	Housekeeping	88,220	13,128	362	101,710		101,710		101,710			3
4	Laundry	73,303	8,416		81,719		81,719		81,719			4
5	Heat and Other Utilities			70,703	70,703		70,703		70,703			5
6	Maintenance	56,712	23,038	49,161	128,911		128,911		128,911			6
7	Other (specify):*											7
8	TOTAL General Services	464,354	190,131	128,619	783,104		783,104	(6,718)	776,386			8
	B. Health Care and Programs											
9	Medical Director			4,440	4,440		4,440		4,440			9
10	Nursing and Medical Records	1,102,418	82,690	137,560	1,322,668		1,322,668	(23,399)	1,299,269			10
10a	Therapy			294,972	294,972		294,972		294,972			10a
11	Activities	58,535	2,462	5,641	66,638		66,638	(622)	66,016			11
12	Social Services	27,498	26		27,524		27,524		27,524			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,188,451	85,178	442,613	1,716,242		1,716,242	(24,021)	1,692,221			16
	C. General Administration											
17	Administrative	68,594			68,594		68,594		68,594			17
18	Directors Fees											18
19	Professional Services			26,703	26,703		26,703		26,703			19
20	Dues, Fees, Subscriptions & Promotions			15,626	15,626		15,626	(1,351)	14,275			20
21	Clerical & General Office Expenses	153,515	33,588	47,039	234,142		234,142	(7,506)	226,636			21
22	Employee Benefits & Payroll Taxes			356,781	356,781		356,781		356,781			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,411	14,411		14,411		14,411			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,481	36,481		36,481		36,481			26
27	Other (specify):*											27
28	TOTAL General Administration	222,109	33,588	497,041	752,738		752,738	(8,857)	743,881			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,874,914	308,897	1,068,273	3,252,084		3,252,084	(39,596)	3,212,488			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Arthur Home #0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,149	72,149		72,149		72,149			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,532	9,532		9,532	(9,532)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			81,681	81,681		81,681	(9,532)	72,149			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,377		134,377		134,377	(20,697)	113,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,665	31,665		31,665		31,665			42
43	Other (specify):* **AL & Miscellaneous**			1,332,468	1,332,468		1,332,468	(1,333,746)	(1,278)			43
44	**TOTAL Special Cost Centers**		134,377	1,364,133	1,498,510		1,498,510	(1,354,443)	144,067			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,874,914	443,274	2,514,087	4,832,275		4,832,275	(1,403,571)	3,428,704			45

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,463)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,605)	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				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	(547)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,279)	43		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	(55,912)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,332,765)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,403,571)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,403,571)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

The Arthur Home

ID# 0005462

Report Period Beginning: 9/1/2009

Ending: 8/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Ray - Medicare Expense	$ (3,228)	39	1
2	Lab - Medicare Expense	(17,469)	39	2
3	Eberhardt Village, Inc. (Assisted Living) Expenses	(1,268,403)	43	3
4	Interest Income	(9,532)	32	4
5	Social Dues Expense	(1,012)	20	5
6	Other Income	(2,662)	21	6
7	Activity Income	(622)	11	7
8	Transportation Income	(23,399)	10	8
9	Advertising Expense	(339)	20	9
10	Dietary Income	(1,255)	1	10
11	Grant Revenue	(4,844)	21	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**	(1,332,765)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arthur Home # 0005462 **Report Period Beginning:** 9/1/2009 **Ending:** 8/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,255)	0	0	0	0	0	0	0	0	0	0	(1,255)	1
2	Food Purchase	(5,463)	0	0	0	0	0	0	0	0	0	0	(5,463)	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**	(6,718)	0	0	0	0	0	0	0	0	0	0	(6,718)	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	(23,399)	0	0	0	0	0	0	0	0	0	0	(23,399)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(622)	0	0	0	0	0	0	0	0	0	0	(622)	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**	(24,021)	0	0	0	0	0	0	0	0	0	0	(24,021)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,351)	0	0	0	0	0	0	0	0	0	0	(1,351)	20
21	Clerical & General Office Expenses	(7,506)	0	0	0	0	0	0	0	0	0	0	(7,506)	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**	(8,857)	0	0	0	0	0	0	0	0	0	0	(8,857)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,596)	0	0	0	0	0	0	0	0	0	0	(39,596)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arthur Home **#** 0005462 **Report Period Beginning:** 9/1/2009 **Ending:** 8/31/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,532)	0	0	0	0	0	0	0	0	0	0	(9,532)	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**	(9,532)	0	0	0	0	0	0	0	0	0	0	(9,532)	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	(20,697)	0	0	0	0	0	0	0	0	0	0	(20,697)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,333,746)	0	0	0	0	0	0	0	0	0	0	(1,333,746)	43
44	**TOTAL Special Cost Centers**	(1,354,443)	0	0	0	0	0	0	0	0	0	0	(1,354,443)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,403,571)	0	0	0	0	0	0	0	0	0	0	(1,403,571)	45

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See attached listing of board members. No board members receive compensation.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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 [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	State Bank of Arthur		X	Working Capital	None	8/30/2006	300,000	213,680	3/10/2011	5.0000	9,532	6
7												7
8												8
9	TOTAL Facility Related						$ 300,000	$ 213,680			$ 9,532	9
	B. Non-Facility Related*											
10	USDA		X	Construction	$24,886.00	3/2/2007	5,721,000	5,721,000	3/1/2047	4.1250	235,991	10
11	State Bank of Arthur		X	Construction	$3,845.00	8/27/2008	375,000	375,000	8/27/2023	5.0000	18,750	11
12	State Bank of Arthur		X	Working Capital	None	5/17/2008	600,000	591,521	12/31/2010	5.0000	27,599	12
13												13
14	TOTAL Non-Facility Related				$28,731.00		$ 6,696,000	$ 6,687,521			$ 282,340	14
15	TOTALS (line 9+line14)						$ 6,996,000	$ 6,901,201			$ 291,872	15

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

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

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

Facility Name & ID Number The Arthur Home **#** 0005462 **Report Period Beginning:** 9/1/2009 **Ending:** 8/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arthur Home COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT David Eversole

TELEPHONE 217-543-2103 FAX #: 217-543-2278

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes on		$	$
2.	non-care assets. All costs are		$	$
3.	adjusted out of report		$	$
4.			$	$
5.	03-03-25-406-012	PT SW 1/4 SE 1/4	$ 70,743.04	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,743.04	$

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? X YES ____ NO

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,236 B. General Construction Type: Exterior Brick Veneer Frame Concrete, Steel, Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Eberhardt Village, Inc. - assisted living facility - 40,000 square feet - 36 beds

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	152,469	1959	$ 2,085	1
2					2
3	TOTALS	152,469		$ 2,085	3

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1959	1959	$ 124,966	$	33	$	$	$ 124,966	4
5	20		1975	1975	308,252		33			308,252	5
6											6
7											7
8											8
	Improvement Type**										
9	New Roof			1972	1,988		10			1,988	9
10	Fire Sprinkler System			1973	20,020		10			20,020	10
11	Fire Door			1973	2,400		10			2,400	11
12	Building Improvements			1973	2,646		10			2,646	12
13	Front Step and Ramp			1974	204		10			204	13
14	Heat Ducts			1974	942		10			942	14
15	Electric Breaker and Box			1974	30		10			30	15
16	Night Lights			1974	1,499		10			1,499	16
17	Heater for Ramp			1974	465		10			465	17
18	Concrete On Step & Ramp			1974	3,398		10			3,398	18
19	Pipe Insulation			1975	89		10			89	19
20	Field Tile			1975	54		10			54	20
21	Door Holder			1975	78		10			78	21
22	Water Heater			1975	1,461		10			1,461	22
23	Ward Door			1975	275		10			275	23
24	Concrete			1975	83		10			83	24
25	Plumbing			1975	57		10			57	25
26	Electrical			1976	677		10			677	26
27	Concrete			1976	2,884		10			2,884	27
28	Lights in Parking Lot			1976	327		10			327	28
29	Doors			1976	1,011		10			1,011	29
30	Insulation			1977	3,094		10			3,094	30
31	Roof Fan and Cooler			1978	2,252		10			2,252	31
32	Building Improvements			1978	1,316		10			1,316	32
33	Building Improvements			1978	451		10			451	33
34	Seamless Floors			1979	9,036		10			9,036	34
35	Building Improvements			1979	4,228		10			4,228	35
36	Remodeling Kitchen			1980	12,772		10			12,772	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1980	$ 552	$	10	$	$	$ 552	37
38	Roof	1981	23,816		10			23,816	38
39	Water Heater	1982	769		10			769	39
40	Parking Lot Addition	1982	4,577		10			4,577	40
41	Wood Folding Doors/Shade	1982	1,728		10			1,728	41
42	Remodeling Heating System	1982	22,500		10			22,500	42
43	Sewerage Improvements	1983	2,604		10			2,604	43
44	New Overhang	1983	4,120		10			4,120	44
45	Over Hang	1983	2,210		10			2,210	45
46	New Roof	1984	11,137		10			11,137	46
47	Firecode Paintroom	1985	1,214		10			1,214	47
48	New Front Doors	1985	2,333		10			2,333	48
49	New Bath & Beauty Shop	1986	13,969		10			13,969	49
50	Remodel Medicine Room	1986	1,886		10			1,886	50
51	Sprinkler System-Boiler Room	1987	1,971	79	25	79		1,840	51
52	Fire Doors	1987	1,097		10			1,097	52
53	Garage	1987	6,834		20			6,834	53
54	Boiler & Furnace Room	1987	96,626	3,865	25	3,865		89,862	54
55	Points on Construction Loan	1987	1,300	52	25	52		1,209	55
56	Floor Replacement	1987	1,016		20			1,016	56
57	New Water Heater	1987	3,238		15			3,238	57
58	Gargage Wiring	1987	916		20			916	58
59	Floor Replacement	1988	900		20			900	59
60	Replacement Windows	1988	2,100		20			2,100	60
61	Doorways-Widening	1989	401		20			401	61
62	Sprinkler System-Kitchen	1989	2,523	101	25	101		2,179	62
63	Patio	1989	2,384		20			2,384	63
64	Kitchen Fire System	1989	1,005	40	25	40		838	64
65	New Flooring	1990	35,477	739	20	739		35,477	65
66	Shower Room Remodeling	1990	2,111	52	20	52		2,111	66
67	Basement Remodeling	1990	5,913	172	20	172		5,913	67
68	Patient Alarm System	1990	3,172		10			3,172	68
69	Curtain Tracks	1991	679		10			679	69
70	TOTAL (lines 4 thru 69)		$ 770,033	$ 5,100		$ 5,100	$	$ 762,537	70

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 770,033	$ 5,100		$ 5,100	$	$ 762,537	1
2	Door	1992	2,056		10			2,056	2
3	Ramp	1992	6,007	240	25	240		4,445	3
4	Gazebo	1992	10,636	532	20	532		9,794	4
5	Sprinkler System	1992	22,385	895	25	895		16,415	5
6	Building Improvements	1992	1,560	78	20	78		1,417	6
7	Electrical Heat Mats	1992	2,450	123	20	123		2,186	7
8	Roof	1992	1,569	78	20	78		1,385	8
9	Guttering	1993	1,362	68	20	68		1,203	9
10	Free Air Vents	1992	814	41	20	41		723	10
11	Remodel/D.O.N. Office	1993	3,970	199	20	199		3,442	11
12	Air Conditioner-Vent Work	1993	4,679		10			4,679	12
13	Fans & Lights	1993	802	40	20	40		675	13
14	Ramp, Rail & Heater	1993	8,030	401	20	401		6,724	14
15	Roof Work	1994	3,150	158	20	158		2,600	15
16	Curtains	1994	382	19	20	19		313	16
17	Kitchen Windows	1994	300	15	20	15		244	17
18	Water Heater	1994	1,958		10			1,958	18
19	Bed Lights	1994	2,707		10			2,707	19
20	Windows	1995	39,488	1,974	20	1,974		29,944	20
21	Flooring	1995	454	23	20	23		354	21
22	Nurse Call System	1995	10,082		10			10,082	22
23	Doors	1995	2,733	137	20	137		2,073	23
24	Hot Water Pipes	1996	2,576	129	20	129		1,868	24
25	Shower Room Remodeling	1996	1,707	85	20	85		1,208	25
26	Lights	1996	1,366	68	20	68		950	26
27	Air Conditioner	1996	4,730		10			4,730	27
28	Lavatory	1996	1,778	89	20	89		1,230	28
29	Flooring	1997	15,671	784	20	784		10,645	29
30	Recover Walls	1997	27,143		10			27,143	30
31	Miscellaneous Improvements	1997	2,679	134	20	134		1,808	31
32	Insulation	1998	3,600	180	20	180		2,160	32
33	Basement Steel Posts	1998	4,639	232	20	232		2,880	33
34	TOTAL (lines 1 thru 33)		$ 963,496	$ 11,822		$ 11,822	$	$ 922,578	34

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 963,496	$ 11,822		$ 11,822	$	$ 922,578	1
2	Architectural Fees-Addition	1998	10,950	548	20	548		6,800	2
3	Air Conditioner	1997	6,752		10			6,752	3
4	Miscellaneous Bldg Improvements	1998	2,802	140	20	140		1,751	4
5	Parking Spaces	1998	1,596	64	25	64		746	5
6	Exhaust Fans	1999	221	11	20	11		128	6
7	Install Steel Plates Over Gutters	1999	484	24	20	24		264	7
8	Sink & Faucet	2000	1,401	93	15	93		995	8
9	Ducts	2000	404	20	20	20		214	9
10	Basement Door	2001	1,058	53	20	53		512	10
11	Back Doors	2001	2,687	134	20	134		1,242	11
12	Alarm System	2001	2,075	208	10	208		1,973	12
13	Ceiling Imp	2001	500	25	20	25		227	13
14	Grease Trap	2001	2,531	127	20	127		1,140	14
15	New Roof	2002	27,023	1,351	20	1,351		10,864	15
16	Miscellaneous Improvements	2002	1,489	74	20	74		632	16
17	Fire Sprinkler	2003	2,653	177	15	177		1,194	17
18	Cabinet	2004	748	75	10	75		499	18
19	Cabinet	2004	748	75	10	75		499	19
20	Draperies	2004	1,672	167	10	167		1,073	20
21	Draperies	2004	1,806	181	10	181		1,100	21
22	Sewer Line	2004	4,200	280	15	280		1,703	22
23	Shower Room Tile	2005	3,675	368	10	368		2,237	23
24	Draperies	2005	632	63	10	63		385	24
25	Counter Top	2005	980	98	10	98		596	25
26	Kitchen Tile Floor	2005	1,560	156	10	156		949	26
27	Cabinet	2005	755	76	10	76		461	27
28	Cabinet	2005	695	70	10	70		424	28
29	Exhaust Fan	2004	1,782	178	10	178		958	29
30	Back Step	2004	2,545	170	15	170		1,040	30
31	Basement Work	2005	10,465	523	20	523		2,878	31
32	Handrails	2005	7,045	470	15	470		2,545	32
33	Doors	2005	557	56	10	56		298	33
34	TOTAL (lines 1 thru 33)		$ 1,067,986	$ 17,877		$ 17,877	$	$ 975,657	34

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,067,986	$ 17,877		$ 17,877	$	$ 975,657	1
2	Carpet	2005	1,550	155	10	155		814	2
3	Ramps	2005	1,827	122	15	122		655	3
4	Doors	2005	1,000	117	10	117		606	4
5	Roof	2005	8,000	400	20	400		2,133	5
6	Roof	2005	8,000	400	20	400		2,133	6
7	Roof	2005	16,285	802	20	802		4,313	7
8	Smoke Detectors	2006	4,785	479	10	479		2,194	8
9	Concrete Patio	2006	733	37	20	37		150	9
10	Doors	2007	4,076	204	20	204		731	10
11	Fire Doors	2007	3,163	158	20	158		540	11
12	Concrete	2007	595	60	10	60		199	12
13	Concrete	2007	2,285	229	10	229		763	13
14	Ramp Railing	2007	1,325	133	10	133		432	14
15	Bathroom Remodeling	2007	1,080	54	20	54		167	15
16	Doors	2006	2,280	114	20	114		351	16
17	Prinsco-Tile Work	2007	2,772	277	10	277		854	17
18	Data Wiring Addition	2007	5,400	540	10	540		1,440	18
19	Energy Recovery Ventilator	2008	1,096	110	10	110		284	19
20	Data Addition	2008	2,737	274	10	274		708	20
21	Exterior Light Fixtures	2008	551	55	10	55		138	21
22	Fire Alarm System	2008	1,360	136	10	136		329	22
23	Data Addition	2008	8,137	814	10	814		1,967	23
24	Boiler	2008	612	31	20	31		67	24
25	Chair Rail	2008	528	53	10	53		110	25
26	Air Conditioner	2008	2,726	273	10	273		546	26
27	Code Alert Alarm	2008	790	79	10	79		165	27
28	Floor Tile	2008	504	50	10	50		97	28
29	Smoke Shack Floor	2008	625	31	20	31		57	29
30	Door Between AH & Offices	2008	625	31	20	31		55	30
31	Activated Light	2008	561	56	10	56		94	31
32	Sprinkler Heads	2009	992	99	10	99		165	32
33	Windows (14) Parkview	2009	6,628	442	20	442		736	33
34	TOTAL (lines 1 thru 33)		$ 1,161,614	$ 24,692		$ 24,692	$	$ 999,650	34

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,161,614	$ 24,692		$ 24,692	$	$ 999,650	1
2	Plumbing	2009	945	95	10	95		158	2
3	Basement Wall	2009	5,604	280	20	280		420	3
4	Room Remodel	2009	4,923	246	20	246		369	4
5	Sprinkler Heads	2009	1,127	56	20	56		85	5
6	Concrete-Patio	2009	797	40	20	40		53	6
7	Steps-Patio	2009	599	30	20	30		40	7
8	Lights-Hall 20	2009	1,054	70	15	70		94	8
9	Front Porch	2009	1,172	59	20	59		73	9
10	Bathroom Remodeling	2009	1,053	53	20	53		66	10
11	Carpet	2009	504	50	10	50		55	11
12	Front Sidewalk	2009	1,125	56	20	56		61	12
13	Fence	2009	4,231	423	10	423		423	13
14	Asbestos Inspection	2009	596	109	3	109		109	14
15	Lumber	2009	529	44	10	44		44	15
16	Wallpaper	2010	2,000	67	10	67		67	16
17	Front Sidewalk	2010	628	10	10	10		10	17
18	Wallpaper Remodel	2010	2,653	44	10	44		44	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	TOTAL (lines 1 thru 33)		$ 1,191,154	$ 26,424		$ 26,424	$	$ 1,001,821	34

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 370,349	$ 41,352	$ 41,352	$	Various	$ 208,209	71
72	Current Year Purchases	10,180	495	495		Various	495	72
73	Fully Depreciated Assets	544,491	2,203	2,203		Various	544,491	73
74								74
75	TOTALS	$ 925,020	$ 44,050	$ 44,050	$		$ 753,195	75

D. Vehicle Depreciation (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	Resident Care	Van	1986	$ 7,000	$	$	$	4	$ 7,000	76
77	Resident Care	1991 Aerostar Van	1991	15,110				4	15,110	77
78	Resident Care	Handicap Bus	2001	45,103				4	45,103	78
79	Resident Care	Van & Conversion	2010	13,400	1,675	1,675		4	1,675	79
80	TOTALS			$ 80,613	$ 1,675	$ 1,675	$		$ 68,888	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)	$ 2,198,872	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,149	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,149	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,823,904	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	8 Acres Donated Farm Land	$ 22,500	$	$	86
87	8.8 Acres - Lutheran Church Dist.	81,771			87
88	Funeral Home Property	143,696			88
89	Parking Lot Roadpack	6,015			89
90	(See attachment for further detail)	6,895,735	183,573	383,048	90
91	TOTALS	$ 7,149,717	$ 183,573	$ 383,048	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

No C N A training was performed at the facility during this reporting period due to C N As receiving training elsewhere.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	1,627	$ 92,731	$	1,627	$ 92,731	1
2	Licensed Speech and Language Development Therapist		hrs		1,065	83,341		1,065	83,341	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,970	118,114		1,970	118,114	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	4,662	$ 294,186	$	4,662	$ 294,186	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.

STATE OF ILLINOIS

Facility Name & ID Number The Arthur Home # 0005462 **Report Period Beginning:** 9/1/2009 **Ending:** 8/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 8/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 90,977	$ 101,135	1
2	Cash-Patient Deposits	9,454	36,274	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,500)	434,597	440,041	3
4	Supply Inventory (priced at)	9,379	9,965	4
5	Short-Term Investments			5
6	Prepaid Insurance	11,362	13,363	6
7	Other Prepaid Expenses	2,222	4,009	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Contributions Receivable	315,498	315,498	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 873,489	$ 920,285	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,067	274,067	13
14	Buildings, at Historical Cost	882,902	7,454,852	14
15	Leasehold Improvements, at Historical Cost	308,252	326,891	15
16	Equipment, at Historical Cost	1,005,633	1,310,779	16
17	Accumulated Depreciation (book methods)	(1,817,200)	(2,206,952)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Due From Related En	1,108,472		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,548,126	$ 7,159,637	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,421,615	$ 8,079,922	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 176,702	$ 194,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,454	37,274	28
29	Short-Term Notes Payable	213,680	805,201	29
30	Accrued Salaries Payable	109,586	127,592	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		81,338	32
33	Accrued Interest Payable		586,542	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	14,497	15,172	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 523,919	$ 1,848,056	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		375,000	39
40	Mortgage Payable		5,721,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,096,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 523,919	$ 7,944,056	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,897,696	$ 135,866	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,421,615	$ 8,079,922	48

***(See instructions.)**

Facility Name & ID Number The Arthur Home # 0005462 **Report Period Beginning:** 9/1/2009 **Ending:** 8/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 838,473	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 838,473	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(702,607)	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)**	$ (702,607)	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)**	$ 135,866	24 *

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,078,166	1
2	Discounts and Allowances for all Levels	(12,732)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,065,434	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	320,118	6
7	Oxygen	33,997	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 354,115	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,463	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	165,752	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,408	19
20	Radiology and X-Ray	3,771	20
21	Other Medical Services	1,416	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 192,810	23
	D. Non-Operating Revenue		
24	Contributions	28,751	24
25	Interest and Other Investment Income***	35,061	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 63,812	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	453,497	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 453,497	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,129,668	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	783,104	31
32	Health Care	1,716,242	32
33	General Administration	752,738	33
	B. Capital Expense		
34	Ownership	81,681	34
	C. Ancillary Expense		
35	Special Cost Centers	1,466,845	35
36	Provider Participation Fee	31,665	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,832,275	40
41	**Income before Income Taxes (line 30 minus line 40)****	(702,607)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (702,607)	43

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

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 67,566	$ 32.48	1
2	Assistant Director of Nursing	1,874	2,040	49,087	24.06	2
3	Registered Nurses	6,305	6,644	155,918	23.47	3
4	Licensed Practical Nurses	14,200	14,924	305,065	20.44	4
5	CNAs & Orderlies	41,757	45,188	478,958	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,497	3,832	45,824	11.96	8
9	Activity Director	1,756	1,997	24,397	12.22	9
10	Activity Assistants	3,616	3,717	34,138	9.18	10
11	Social Service Workers	2,049	2,229	27,498	12.34	11
12	Dietician					12
13	Food Service Supervisor	1,871	2,026	23,037	11.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,773	23,267	223,082	9.59	15
16	Dishwashers					16
17	Maintenance Workers	4,254	4,637	56,712	12.23	17
18	Housekeepers	7,944	8,664	88,220	10.18	18
19	Laundry	6,947	7,433	73,303	9.86	19
20	Administrator	1,837	2,080	68,594	32.98	20
21	Assistant Administrator					21
22	Other Administrative	5,295	6,050	114,638	18.95	22
23	Office Manager	1,976	2,162	38,877	17.98	23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,927	138,970	$ 1,874,914 *	$ 13.49	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	93	$ 4,229	1-3	35
36	Medical Director	Monthly	4,440	9-3	36
37	Medical Records Consultant	12	800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	1,808	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,842	11-3	44
45	Social Service Consultant	24	1,842	11-3	45
46	Other(specify) Dental Consultant	12	1,260	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	225	$ 16,221		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	281	$ 13,407	10-3	50
51	Licensed Practical Nurses	229	8,503	10-3	51
52	Certified Nurse Assistants/Aides	5,053	110,967	10-3	52
53	TOTAL (lines 50 - 52)	5,563	$ 132,877		53

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Eversole	Administrator		$ 68,594
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,594

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LarsonAllen LLP	Accounting	$ 22,924
Samuels, Miller, Jackson, Schroeder,	Legal	3,779
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,703

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,423
Unemployment Compensation Insurance	9,430
FICA Taxes	139,850
Employee Health Insurance	118,165
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	2,209
Pension Contributions	9,704
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,781

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,671
Health Care Worker Background Check	
(Indicate # of checks performed 59)	590
Patient Background Checks 52	520
Misc Subscriptions	54
Vehicle License	109
Dues	3,389
Other Licenses	1,508
Other Taxes	1,785
Less: Public Relations Expense	(1,012)
Non-allowable advertising	(339)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,275

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,438
Seminar Expense	7,973
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,411

**See instructions.

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The Arthur Home # 0005462 **Report Period Beginning:** 9/1/2009 **Ending:** 8/31/2010

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**
If YES, give association name and amount. **LSN - $2,173; AAHSA - $1,214**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,407** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **31,665**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,463**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **23,399**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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: **LarsonAllen LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.