FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0023382

Facility Name: Eden Village Care Center

Address: 400 South Station Road (Number) Glen Carbon (City) 62034 (Zip Code)

County: Madison

Telephone Number: (618) 288-5014 **Fax #** (618) 288-0206

HFS ID Number:

Date of Initial License for Current Owners: 5/14/1979

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: Allan B. Larson, CPA **Telephone Number:** (314) 925-4379
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 1/1/2012 to 12/31/2012 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) Ron Hassler
(Title) Director of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Allan B. Larson, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen, 600 Washington Ave, Ste 1800, St. Louis 63101
(Telephone) (314) 925-4300 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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1 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	128	Skilled (SNF)	128	46,848	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	128	TOTALS	128	46,848	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	10,696	18,559	5,764	35,019	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,696	18,559	5,764	35,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.75%

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)

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 05/14/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/14/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 3,798

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: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	382,848	66,631	31,980	481,459		481,459	(174,594)	306,865			1
2	Food Purchase		569,972		569,972		569,972	(329,071)	240,901			2
3	Housekeeping	289,886	80,474		370,360		370,360	(95,931)	274,429			3
4	Laundry							(38,051)	(38,051)			4
5	Heat and Other Utilities			465,122	465,122		465,122	(384,698)	80,424			5
6	Maintenance	230,488	559	293,878	524,925		524,925	(297,926)	226,999			6
7	Other (specify):*											7
8	TOTAL General Services	903,222	717,636	790,980	2,411,838		2,411,838	(1,320,271)	1,091,567			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	2,274,193	234,027	71,159	2,579,379		2,579,379	(47,699)	2,531,680			10
10a	Therapy	69	1,986	580,682	582,737		582,737		582,737			10a
11	Activities	510,649	10,936	9,294	530,879		530,879	(384,069)	146,810			11
12	Social Services	78,760	4,230	4,228	87,218		87,218		87,218			12
13	CNA Training											13
14	Program Transportation	38,660	4,418	2,893	45,971		45,971	(35,312)	10,659			14
15	Other (specify):* Seniors N Motion	14,476	75		14,551		14,551	(14,551)				15
16	TOTAL Health Care and Programs	2,916,807	255,672	685,056	3,857,535		3,857,535	(481,631)	3,375,904			16
	C. General Administration											
17	Administrative	144,835		98,751	243,586		243,586	(219,783)	23,803			17
18	Directors Fees											18
19	Professional Services			35,210	35,210		35,210		35,210			19
20	Dues, Fees, Subscriptions & Promotions			60,775	60,775		60,775	(43,341)	17,434			20
21	Clerical & General Office Expenses	207,196	40,160	116,130	363,486		363,486	(160,336)	203,150			21
22	Employee Benefits & Payroll Taxes			920,324	920,324		920,324	(172,193)	748,131			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,851	4,851		4,851		4,851			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			163,094	163,094		163,094	(134,893)	28,201			26
27	Other (specify):* Supplies & Mktg/Development		3,074	8,828	11,902		11,902	(11,902)				27
28	TOTAL General Administration	352,031	43,234	1,407,963	1,803,228		1,803,228	(742,448)	1,060,780			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,172,060	1,016,542	2,883,999	8,072,601		8,072,601	(2,544,350)	5,528,251			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 Eden Village Care Center #0023382 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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			216,656	216,656		216,656		216,656			30
31	Amortization of Pre-Op. & Org.			28,272	28,272		28,272		28,272			31
32	Interest			1,240,513	1,240,513		1,240,513	(1,202,216)	38,297			32
33	Real Estate Taxes			326,167	326,167		326,167	(326,167)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,811,608	1,811,608		1,811,608	(1,528,383)	283,225			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			226,668	226,668		226,668		226,668			39
40	Barber and Beauty Shops	58,239	5,061	52	63,352		63,352	(32,312)	31,040			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			252,895	252,895		252,895		252,895			42
43	Other (specify):* **Retirement Center**			760,596	760,596		760,596	(571,144)	189,452			43
44	**TOTAL Special Cost Centers**	58,239	5,061	1,240,211	1,303,511		1,303,511	(603,456)	700,055			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,230,299	1,021,603	5,935,818	11,187,720		11,187,720	(4,676,189)	6,511,531			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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	(14,551)	15		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20,795)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,431)	17		24
25	Fund Raising, Advertising and Promotional	(43,341)	20		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	(4,340,724)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,499,842)		$	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))**	$ (4,499,842)		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

Eden Village Care Center

ID# 0023382

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RC-Dietary	$ (174,594)	1	1
2	RC-Food	(308,276)	2	2
3	RC-Housekeeping	(95,931)	3	3
4	RC-Laundry	(38,051)	4	4
5	RC-Heat & Utilities	(384,698)	5	5
6	RC-Maintainance	(264,568)	6	6
7	RC-Program Transportation	(23,897)	14	7
8	RC-Administrative	(139,352)	17	8
9	RC-Clerical & Office	(130,031)	21	9
10	RC-Employee Benefits/PR Taxes	(172,193)	22	10
11	RC-Insurance	(134,893)	26	11
12	RC-Direct Expenses (Depreciation)	(535,711)	43	12
13	RC-Activities Salaries	(384,069)	11	13
14	RC-Receptionists	(47,699)	10	14
15	Real Estate Taxes on RC	(326,167)	33	15
16	Marketing/Development Salaries	(11,902)	27	16
17	Lab, Xray, Ambulance services	(35,433)	43	17
18	RC - Interest Expense on RC building	(1,202,216)	32	18
19	RC- Barber & Beauty	(32,312)	40	19
20	Other Revenue - Personal Purchases Misc.	(11,772)	21	20
21	Other Revenue - Transportation	(11,415)	14	21
22	Other Revenue - Senior TV	(33,358)	6	22
23	Other Revenue - Internet Purchases	(1,757)	21	23
24	Other Revenue - Phone Revenue CC Residents	(16,776)	21	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**	(4,517,071)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(174,594)	0	0	0	0	0	0	0	0	0	0	(174,594)	1
2	Food Purchase	(329,071)	0	0	0	0	0	0	0	0	0	0	(329,071)	2
3	Housekeeping	(95,931)	0	0	0	0	0	0	0	0	0	0	(95,931)	3
4	Laundry	(38,051)	0	0	0	0	0	0	0	0	0	0	(38,051)	4
5	Heat and Other Utilities	(384,698)	0	0	0	0	0	0	0	0	0	0	(384,698)	5
6	Maintenance	(297,926)	0	0	0	0	0	0	0	0	0	0	(297,926)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,320,271)	0	0	0	0	0	0	0	0	0	0	(1,320,271)	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	(47,699)	0	0	0	0	0	0	0	0	0	0	(47,699)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(384,069)	0	0	0	0	0	0	0	0	0	0	(384,069)	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	(35,312)	0	0	0	0	0	0	0	0	0	0	(35,312)	14
15	Other (specify):*	(14,551)	0	0	0	0	0	0	0	0	0	0	(14,551)	15
16	**TOTAL Health Care and Programs**	(481,631)	0	0	0	0	0	0	0	0	0	0	(481,631)	16
	C. General Administration													
17	Administrative	(219,783)	0	0	0	0	0	0	0	0	0	0	(219,783)	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	(43,341)	0	0	0	0	0	0	0	0	0	0	(43,341)	20
21	Clerical & General Office Expenses	(160,336)	0	0	0	0	0	0	0	0	0	0	(160,336)	21
22	Employee Benefits & Payroll Taxes	(172,193)	0	0	0	0	0	0	0	0	0	0	(172,193)	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	(134,893)	0	0	0	0	0	0	0	0	0	0	(134,893)	26
27	Other (specify):*	(11,902)	0	0	0	0	0	0	0	0	0	0	(11,902)	27
28	**TOTAL General Administration**	(742,448)	0	0	0	0	0	0	0	0	0	0	(742,448)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,544,350)	0	0	0	0	0	0	0	0	0	0	(2,544,350)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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	(1,202,216)	0	0	0	0	0	0	0	0	0	0	(1,202,216)	32
33	Real Estate Taxes	(326,167)	0	0	0	0	0	0	0	0	0	0	(326,167)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,528,383)	0	0	0	0	0	0	0	0	0	0	(1,528,383)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(32,312)	0	0	0	0	0	0	0	0	0	0	(32,312)	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):*	(571,144)	0	0	0	0	0	0	0	0	0	0	(571,144)	43
44	**TOTAL Special Cost Centers**	(603,456)	0	0	0	0	0	0	0	0	0	0	(603,456)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,676,189)	0	0	0	0	0	0	0	0	0	0	(4,676,189)	45

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	John Dorsey	BOD						1
2	Kimberly Durr	BOD						2
3	Dr. Max Eakin	BOD						3
4	Ted Eilerman	BOD						4
5	Janet Foehrkolb	BOD						5
6	Charlotte Frisbie	BOD						6
7	Len Haleen	BOD						7
8	Pam Heepke	BOD						8
9	Dan Highlander	BOD						9
10	John Roberts	BOD						10
11	David Oates	BOD						11
12	Don Sullivan	BOD						12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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									$		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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	Series 2006 Revenue Bonds		X	Construction & Equipment		12/1/2006	$ 22,390,000	$ 20,830,000	12/1/2036	5.00-5.85%	$ 1,202,215	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Bank of Edwardsville		X	Operations LOC		8/11/2008	1,050,000	900,000			38,298	6
7												7
8												8
9	TOTAL Facility Related						$ 23,440,000	$ 21,730,000			$ 1,240,513	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 23,440,000	$ 21,730,000			$ 1,240,513	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 Eden Village Care Center # 0023382 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 446,589	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.)		$ 368,658	2
3. Under or (over) accrual (line 2 minus line 1).		$ (77,931)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 404,098	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.		$ 326,167	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	63,416	8
	2008	65,428	9
	2009	311,564	10
	2010	197,411	11
	2011	368,658	12

$315,658 payments relate to 2011 Real Estate Taxes and the remaining $53,000 relates to 2010 Real Estate Taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eden Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023382

CONTACT PERSON REGARDING THIS REPORT Ron Hassler

TELEPHONE (618) 288-5014 FAX #: (618) 288-0206

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-2-15-26-02-202-096	Cottonwood Trace PT Lot 3	$ 103.76	$
2.	14-1-15-26-02-202-098.001	NE/C NE	$ 58.80	$
3.	14-2-15-26-02-202-101	Cottonwood Trace-First Add LT PT 8	$ 1,294.08	$
4.	14-2-15-26-02-202-097	Cottonwood Trace PT Lot 2	$ 9,263.56	$
5.	14-2-15-26-02-202-165	Eden Village Subd 1st Addn Lot 1	$ 59,051.32	$
6.	14-2-15-26-02-202-100	Cottonwood Trace First Add PT Lots	$ 245,886.64	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 315,658.16	$

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,924 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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).

Eden Retirement Center, Independent Living Facility (82 apartments; 40 duplex units)
Eden Retirement Center, Assisted Living Facility (74 units)

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	Land-SNF		1979	$ 166,295	1
2					2
3	TOTALS			$ 166,295	3

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	128		1979	1979	$ 2,008,520	$	30	$	$	$ 2,008,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Fixed Assets			1979	63,646		Various			63,646	9
10	1985 Fixed Assets			1985	28,768	959	Various	959		26,131	10
11	1989 Fixed Assets			1989	21,453		Various			21,453	11
12	1990 Fixed Assets			1990	34,575	1,152	Various	1,152		25,739	12
13	1991 Fixed Assets			1991	20,835	358	Various	358		19,742	13
14	1992 Fixed Assets			1992	106,730	4,194	Various	4,194		86,462	14
15	1993 Fixed Assets			1993	68,267	2,558	Various	2,558		57,653	15
16	1994 Fixed Assets			1994	42,035	910	Various	910		37,170	16
17	1995 Fixed Assets			1995	90,923	4,546	Various	4,546		79,126	17
18	1996 Fixed Assets			1996	64,116	2,689	Various	2,689		47,502	18
19	1997 Fixed Assets			1997	6,000	314	Various	314		5,171	19
20	1998 Fixed Assets			1998	1,632,945	40,250	Various	40,250		682,139	20
21	1999 Fixed Assets			1999	620,363	18,047	Various	18,047		280,435	21
22	2000 Fixed Assets			2000	31,137	487	Various	487		21,985	22
23	2001 Fixed Assets			2001	59,749	2,124	Various	2,124		53,023	23
24	2002 Fixed Assets			2002	9,200	368	Various	368		3,722	24
25	2003 Fixed Assets			2003	9,961	662	Various	662		6,219	25
26	2004 Fixed Assets			2004	23,265	1,068	Various	1,068		8,982	26
27	2005 Fixed Assets			2005	178,706	15,597	Various	15,597		123,681	27
28	2006 Fixed Assets			2006	139,502	9,294	Various	9,294		62,355	28
29	2007 Fixed Assets			2007	90,478	6,664	Various	6,664		86,366	29
30	Prof.services Through 7/31/06-3393			2008	189	5	40	5		23	30
31	FLORRING UPGRADE AGMT-3727			2008	22,893	2,289	10	2,289		11,447	31
32	REIMBURSABLE SERVICES TO REPLACE DAMAGED DOORS-3601			2008	8,624	862	10	862		4,312	32
33	MPM Fire Alarm-3745			2008	2,355	471	5	471		2,237	33
34	Altman Charter - PS Doors-3746			2008	6,553	655	10	655		3,004	34
35	WETZEL FAMILY MEMORIAL FOUNTAIN AND BENCHES-3661			2008	6,580	329	20	329		1,481	35
36	SIGN FOR FOUNTAIN-3684			2008	530	27	20	27		115	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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Strip Off Existing Was Clean Floors Hall 6-3809	2010	$ 2,349	$ 783	3	$ 783	$	$ 1,827	37
38	Care Center Wood Floor-	2010	13,024	1,302	10	1,302		2,822	38
39	Strip Wax	2011	1,700	170	10	170		326	39
40	Strip Wax 100 and 200 Common Area	2011	3,995	799	5	799		1,465	40
41	Hall Bath 3	2011	3,620	1,448	3	1,448		2,172	41
42	Roof	2011	25,598	2,560	10	2,560		3,839	42
43	Room 400	2011	4,196	420	10	420		420	43
44	Lizotte Sheet Roof	2011	6,750	338	20	338		338	44
45	Labor And Material For Sprinkler Work 1st Instal	2012	50,000	500	25	500		500	45
46	Second Installment For Sprikler Work	2012	50,000	333	25	333		333	46
47	3rd Installment For Sprinkler Work	2012	50,000	167	25	167		167	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,610,130	$ 125,699		$ 125,699	$	$ 3,844,049	70

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 669,616	$ 68,115	$ 68,115	$		$ 456,658	71
72	Current Year Purchases	32,262	1,733	1,733			1,733	72
73	Fully Depreciated Assets	1,798,360	12,902	12,902			1,798,360	73
74								74
75	TOTALS	$ 2,500,238	$ 82,750	$ 82,750	$		$ 2,256,751	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1990 Van-275	1990	$ 40,188	$	$	$		$ 40,188	76
77	Facility Business	2005 Ford 20 Passenger Bus	2004	54,530	3,635	3,635			29,803	77
78	Facility Business	Wheelchair Accessible Van	2007	45,800	4,572	4,572			24,895	78
79										79
80	TOTALS			$ 140,518	$ 8,207	$ 8,207	$		$ 94,886	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)	$ 8,417,181	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216,656	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 216,656	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)	$ 6,195,686	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	Non-Care Vehicles	$ 62,124	$ 217	$ 61,871	86
87	RC/AL/Apt Duplexes Land	126,596			87
88	Retirement Center/AL/Apts/Duplexes	26,220,753	647,152	7,281,172	88
89					89
90					90
91	TOTALS	$ 26,409,473	$ 647,369	$ 7,343,043	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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 ____

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$	3,932	$ 235,654	$	3,932	$ 235,654	1
2	Licensed Speech and Language Development Therapist		hrs		1,671	87,572		1,671	87,572	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,070	253,256		5,070	253,256	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			$	10,673	$ 576,482	$	10,673	$ 576,482	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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 68,209	$	1
2	Cash-Patient Deposits	3,057		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,402,986		3
4	Supply Inventory (priced at)	23,169		4
5	Short-Term Investments			5
6	Prepaid Insurance	60,592		6
7	Other Prepaid Expenses	400		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	27,474		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,585,887	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	292,891		13
14	Buildings, at Historical Cost	31,208,672		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,325,091		16
17	Accumulated Depreciation (book methods)	(13,538,729)		17
18	Deferred Charges	668,943		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 Debt Service Reserve	1,789,792		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 23,746,660	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 25,332,547	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 386,809	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,057		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	208,501		30
31	Accrued Taxes Payable (excluding real estate taxes)	88,123		31
32	Accrued Real Estate Taxes(Sch.IX-B)	404,098		32
33	Accrued Interest Payable	98,663		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prelease Deposits	277,800		36
37	Other Accrued Expenses and LOC	1,729,935		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,196,986	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	20,830,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	659,735		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 21,489,735	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 24,686,721	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 645,826	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 25,332,547	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 605,033	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 605,033	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	40,793	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)**	$ 40,793	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)**	$ 645,826	24	*

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,868,885	1
2	Discounts and Allowances for all Levels	(1,578,360)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,290,525	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	9,810	5
6	Therapy	397,130	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 406,940	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	21,166	13
14	Non-Patient Meals	20,795	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,945	19
20	Radiology and X-Ray	1,623	20
21	Other Medical Services	105,993	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 152,522	23
	D. Non-Operating Revenue		
24	Contributions	19,293	24
25	Interest and Other Investment Income***	11,859	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31,152	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/Apt/Garden Home Revnue	4,275,218	28
28a	Other Revenue	72,156	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,347,374	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,228,513	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,411,838	31
32	Health Care	3,857,535	32
33	General Administration	1,803,228	33
	B. Capital Expense		
34	Ownership	1,811,608	34
	C. Ancillary Expense		
35	Special Cost Centers	1,233,239	35
36	Provider Participation Fee	70,272	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,187,720	40
41	**Income before Income Taxes (line 30 minus line 40)****	40,793	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 40,793	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,101,670	44
45	Private Pay - Net Inpatient Revenue	3,412,593	45
46	Medicare - Net Inpatient Revenue	1,864,829	46
47	Other-(specify) AL/IL Other	606	47
48	Other-(specify) Charity Care	(89,173)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,290,525	49

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

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

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

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

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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	4,145	4,145	$ 118,772	$ 28.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,485	9,485	227,390	23.97	3
4	Licensed Practical Nurses	30,795	30,795	668,804	21.72	4
5	CNAs & Orderlies	95,637	95,637	1,110,312	11.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,511	7,511	91,959	12.24	10
11	Social Service Workers	5,778	5,778	107,277	18.57	11
12	Dietician					12
13	Food Service Supervisor	2,260	2,260	45,132	19.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,599	33,599	337,716	10.05	15
16	Dishwashers					16
17	Maintenance Workers	13,157	13,157	168,337	12.79	17
18	Housekeepers	21,210	21,210	200,021	9.43	18
19	Laundry	9,529	9,529	89,865	9.43	19
20	Administrator	2,080	2,080	88,062	42.34	20
21	Assistant Administrator					21
22	Other Administrative	6,832	6,832	201,583	29.51	22
23	Office Manager					23
24	Clerical	5,053	5,053	78,932	15.62	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	3,872	3,872	47,989	12.39	31
32	Other Health Care(specify)	1,196	1,196	14,476	12.10	32
33	Other(specify)	53,309	53,309	633,672	11.89	33
34	TOTAL (lines 1 - 33)	305,448	305,448	$ 4,230,299 *	$ 13.85	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	435	$ 13,440	1-3	35
36	Medical Director	224	16,800	9-3	36
37	Medical Records Consultant	13	600	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	22	1,117	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	10	592	11-3	44
45	Social Service Consultant	7	392	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	711	$ 32,941		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	87	$ 3,643	10-3	50
51	Licensed Practical Nurses	819	26,715	10-3	51
52	Certified Nurse Assistants/Aides	561	11,473	10-3	52
53	TOTAL (lines 50 - 52)	1,467	$ 41,832		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Breihan	Administrator	0	$ 44,031
(1/2 of salary is allocated to RCF)			44,031
Tina Kassing	RC Administrator		56,773
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,835

B. Administrative - Other

Description	Amount
Bad Debt	$ 80,431
Interest Expense	12,187
Miscellaneous	(4,522)
TOTAL (agree to Schedule V, line 17, col. 3)	$ 88,096
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mathis Marifian & Richter, LTD	Legal	$ 4,168
CliftonLarsonAllen LLP	Accounting	31,042
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 35,210

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 202,027
Unemployment Compensation Insurance	4,129
FICA Taxes	315,404
Employee Health Insurance	320,860
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
RC Allocation	(172,193)
401K	28,472
General Incentives	50,301
Uniforms	(869)
TOTAL (agree to Schedule V, line 22, col.8)	$ 748,131

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Marketing, Advertising, and PR	43,341
Dues, Subscriptions, and Licenses	17,434
Professional Fees	0
Less: Public Relations Expense	(2,862)
Non-allowable advertising	(40,479)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,434

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,273
Seminar Expense	1,578
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,851

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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. **AAHSA & LSN - $9839**

(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? **N/A**

(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? **N/A**

(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? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,125** Line **10**

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

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

(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. $ **252,895**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **No**
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? **Yes**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CliftonLarsonAllen 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.