



Facility Name & ID Number ARBA CARE CENTER OF COLFAX

# 0052969 Report Period Beginning: 10/01/2014 Ending: 03/31/2015

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	10,920	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	60	10,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			794	794	8
9	SNF/PED					9
10	ICF	4,672	1,176	682	6,530	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,672	1,176	1,476	7,324	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.07%

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  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 10/01/14

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

YES  Date 10/01/14 NO

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

YES  NO  If YES, enter number of beds certified 60 and days of care provided 794

Medicare Intermediary WISCONSIN PHISCIANS SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	83,155	6,054	1,875	91,084		91,084	91,084			1
2	Food Purchase		45,424		45,424		45,424	45,424			2
3	Housekeeping	46,589	2,556		49,145		49,145	49,145			3
4	Laundry	10,217	2,313		12,530		12,530	12,530			4
5	Heat and Other Utilities			53,838	53,838		53,838	53,838			5
6	Maintenance	23,537	6,304	6,562	36,403		36,403	36,403			6
7	Other (specify):*			6,466	6,466		6,466	6,466			7
8	<b>TOTAL General Services</b>	163,498	62,651	68,741	294,890		294,890	294,890			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800	4,800			9
10	Nursing and Medical Records	297,656	30,180	2,214	330,050		330,050	330,050			10
10a	Therapy	26,005			26,005		26,005	26,005			10a
11	Activities	28,524	1,088		29,612		29,612	29,612			11
12	Social Services										12
13	CNA Training										13
14	Program Transportation			1,019	1,019		1,019	1,019			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	352,185	31,268	8,033	391,486		391,486	391,486			16
	<b>C. General Administration</b>										
17	Administrative	41,213		20,000	61,213		61,213	11,321	72,534		17
18	Directors Fees										18
19	Professional Services			68,259	68,259		68,259	(1,000)	67,259		19
20	Dues, Fees, Subscriptions & Promotions			5,579	5,579		5,579	(1,555)	4,024		20
21	Clerical & General Office Expenses	33,154	4,692	39,482	77,328		77,328	7,447	84,775		21
22	Employee Benefits & Payroll Taxes			93,571	93,571		93,571		93,571		22
23	Inservice Training & Education			345	345		345		345		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,630	8,630		8,630	(2,507)	6,123		25
26	Insurance-Prop.Liab.Malpractice			20,047	20,047		20,047		20,047		26
27	Other (specify):*			13,901	13,901		13,901	(12,137)	1,764		27
28	<b>TOTAL General Administration</b>	74,367	4,692	269,814	348,873		348,873	1,569	350,442		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	590,050	98,611	346,588	1,035,249		1,035,249	1,569	1,036,818		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	1,570
	REPAIRS & MAINTENANCE	305
		1,875
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	4,017
	ELECTRICITY	40,731
	WATER	6,336
	CABLE TV - LOBBY	2,754
		53,838
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,906
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,534
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	240
	FIRE SERVICE	882
		6,562
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	6,466
	SECURITY SERVICE	0
		6,466
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,800
		4,800

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	2,214
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		2,214
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,019
		1,019
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	20,000
		20,000
18	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
		0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	26,253
	ADMINISTRATIVE CONSULTANTS XIX C	125
	PROFESSIONAL FEES XIX C	41,881
		68,259
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,555
	EMPLOYEE WANT ADS XIX F	696
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	45
	LICENSES & PERMITS XIX F	2,759
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	524
	PATIENT BACKGROUND CHECKS XIX F	0
		5,579
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	29,404
	EQUIPMENT REPAIR & MAINTENANCE	233
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	9,845
	MESSENGER SERVICE	0
		39,482

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	44,628
	UNEMPLOYMENT COMPENSATION XIX D	15,097
	WORKERS COMPENSATION INSURANC XIX D	23,529
	HOSPITALIZATION INSURANCE XIX D	7,981
	EMPLOYEE BENEFITS - OTHER XIX D	2,246
	EMPLOYEE PHYSICAL EXAMS XIX D	90
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		93,571
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	345
		345
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,630
		8,630
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	20,047
		20,047
27	<b>OTHER</b>	
	BAD DEBTS VI 24	13,901
		13,901

GRAND TOTAL COLUMN 3 OTHER **346,588**

ARBA CARE CENTER OF COLFAX  
SCHEDULES  
03/31/2015

EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	45,424
LESS SALES TAX	<u>0</u>
NET FOOD	45,424

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

TOTAL PATIENT CENSUS	7,324
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	21,972

ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>182</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	21,972
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	21,972

NET FOOD	45,424
DIVIDE TOTAL MEALS/YEAR	<u>21,972</u>

COST PER MEAL	2.07
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

Facility Name & ID Number ARBA CARE CENTER OF COLFAX

#0052969

Report Period Beginning: 10/01/2014 Ending: 03/31/2015

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,710	5,710		5,710	(2,601)	3,109			32
33	Real Estate Taxes			10,200	10,200		10,200		10,200			33
34	Rent-Facility & Grounds			32,503	32,503		32,503		32,503			34
35	Rent-Equipment & Vehicles			3,989	3,989		3,989	(978)	3,011			35
36	Other (specify):* <b>Amortization</b>			1,438	1,438		1,438		1,438			36
37	<b>TOTAL Ownership</b>			53,840	53,840		53,840	(3,579)	50,261			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,569	115,812	133,381		133,381	(12,779)	120,602			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,651	56,651		56,651		56,651			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		17,569	172,463	190,032		190,032	(12,779)	177,253			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	590,050	116,180	572,891	1,279,121		1,279,121	(14,789)	1,264,332			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 ARBA CARE CENTER OF COLFAX

# 0052969

Report Period Beginning: 10/01/2014

Ending: 03/31/2015

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(2,601)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,901)	27		24
25	Fund Raising, Advertising and Promotional	(1,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(18,386)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (36,443)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	21,654		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 21,654</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (14,789)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

ARBA CARE CENTER OF COLFAXID# 0052969Report Period Beginning: 10/01/2014Ending: 03/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	RELATED PARTY THERAPY ADJUSTMENT	\$ (12,779)	39	1
2	NON ALLOWABLE TRAVEL	(3,629)	25	2
3	NON ALLOWABLE LEGAL FEES	(1,000)	19	3
4	AUTO LEASE	(978)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(18,386)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ARBA CARE CENTER OF COLFAX

# 0052969

Report Period Beginning:

10/01/2014

Ending:

03/31/2015

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

	Operating Expenses	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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	11,321	0	0	0	0	0	0	0	0	0	11,321	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,000)	0	0	0	0	0	0	0	0	0	0	(1,000)	19
20	Fees, Subscriptions & Promotions	(1,555)	0	0	0	0	0	0	0	0	0	0	(1,555)	20
21	Clerical & General Office Expenses	0	7,447	0	0	0	0	0	0	0	0	0	7,447	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	(3,629)	1,122	0	0	0	0	0	0	0	0	0	(2,507)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(13,901)	1,764	0	0	0	0	0	0	0	0	0	(12,137)	27
28	<b>TOTAL General Administration</b>	(20,085)	21,654	0	0	0	0	0	0	0	0	0	1,569	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(20,085)	21,654	0	0	0	0	0	0	0	0	0	1,569	29

## STATE OF ILLINOIS

Facility Name & ID Number ARBA CARE CENTER OF COLFAX# 0052969

Report Period Beginning:

10/01/2014 Ending:

Summary B

03/31/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	(2,601)	0	0	0	0	0	0	0	0	0	0	(2,601)	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	(978)	0	0	0	0	0	0	0	0	0	0	(978)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,579)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,579)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(12,779)	0	0	0	0	0	0	0	0	0	0	(12,779)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(12,779)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(12,779)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(36,443)</b>	<b>21,654</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,789)</b>	<b>45</b>

**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
MICHAEL GILLMAN	50			ARBA HEALTHCARE	ELGIN	MANAGEMENT
DARRYLE GILLMAN	50	ARBA CARE CENTER OF BLOOMINGTON	BLOOMINGTON	COMPANY, INC		
		ARBA CARE CENTER OF ELGIN	ELGIN			
		ARBA CARE CENTER OF TOLUCA	TOLUCA			
				ASTA THERAPY		THERAPY

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	\$ 5,000	ARBA HEALTHCARE COMPANY, INC		\$ (5,000)	1
2	V	17	OFFICER'S SALARY-MG			9,288	9,288	2
3	V	17	ADMIN. SALARY- CF			5,889	5,889	3
4	V	17	ADMIN. SALARY- AF			1,144	1,144	4
5	V	21	OFFICE EXPENSE			7,447	7,447	5
6	V	25	STAFF TRANS/TRAVEL			1,122	1,122	6
7	V	27	PAYROLL TAXES			1,764	1,764	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 5,000			\$ 26,654	\$ * 21,654	14

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

Facility Name & ID Number

ARBA CARE CENTER OF COLFAX

# 0052969

Report Period Beginning:

10/01/2014

Ending:

03/31/2015

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ARBA CARE CENTER OF COLFAX # 0052969 Report Period Beginning: 10/01/2014 Ending: 03/31/2015

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN	PRESIDENT	ADMINISTRATIVE	50.00		10	16.67	SALARY	\$ 9,288	17-7	1
2			MANAGEMENT								2
3					SEE	12	20.00				3
4	CRAIG FRANK	CFO	FINANCE/MGMT		ATTACHED			SALARY	5,889	17-7	4
5					SCHEDULE			MGMT FEE	15,000	17-3	5
6											6
7	ALIZA FRANK	PAYROLL CLERK	PAYROLL			10	25.00	SALARY	1,144	17-7	7
8											8
9											9
10	DAVID MEISELMAN	THERAPY MGMNT	management			5	8.33	SALARY	12,344	39-3	10
11											11
12											12
13								TOTAL	\$ 43,665		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 ARBA CARE CENTER OF COLFAX

# 0052969

Report Period Beginning:

10/01/2014

Ending: 3/31/2015

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

Name of Related Organization ARBA HEALTHCARE COMPANY, INC  
 Street Address 134 N. MCLEAN  
 City / State / Zip Code ELGIN, IL 60123  
 Phone Number ( 847 ) 742-8822  
 Fax Number ( 847 ) 742-9013

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	OFFICER'S SALARY-MG	PATIENT DAYS	54,407	4	\$ 69,000	\$ 69,000	7,324	\$ 9,288	1
2	17	ADMIN. SALARY- MG	PATIENT DAYS	54,407	4	43,750	43,750	7,324	5,889	2
3	17	ADMIN. SALARY- AF	PATIENT DAYS	54,407	4	8,500	8,500	7,324	1,144	3
4	21	OFFICE EXPENSE	PATIENT DAYS	54,407	4	55,322	50,212	7,324	7,447	4
5	25	STAFF TRANS/TRAVEL	PATIENT DAYS	54,407	4	8,337		7,324	1,122	5
6	27	PAYROLL TAXES	PATIENT DAYS	54,407	4	13,101		7,324	1,764	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					\$ 198,010	\$ 171,462		\$ 26,654	25

Facility Name & ID Number

ARBA CARE CENTER OF COLFAX

# 0052969

Report Period Beginning:

10/01/2014

Ending:

03/31/2015

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
	<b>Working Capital</b>															
6	PRIVATE BANK		X	LINE OF CREDIT		1/31/15		375,573	1/31/16		3,109					
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$ 375,573			\$ 3,109					
	<b>B. Non-Facility Related*</b>															
10	IRS, IDR, ETC		X	LATE FEES							966					
11	HARRIS BANK										1,188					
12	SEGULA PROPERTIES										447					
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 2,601					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 375,573			\$ 5,710					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2013 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 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>10,200</b>		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>10,200</b>		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	_____	8	<b>FOR BHF USE ONLY</b>		
	2010	_____	9			
	2011	_____	10			
	2012	_____	11			
	2013	<b>15,281</b>	12			
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON THE \$1,700 MONTHLY RE ESCROW PAYMENT REQUIRED FROM OUR LANDLORD</b>				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.**



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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*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 ARBA CARE CENTER OF COLFAX

# 0052969

Report Period Beginning:

10/01/2014

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**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$	\$		\$	\$	\$	70

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



XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	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)	\$	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: SEGULA PROPERTIES

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:		<u>60</u>	<u>10/14</u>	\$ <u>32,503</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>60</b>		\$ <b>32,503</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 10/1/14

Ending 5/31/19

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

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

12. <u>12/31/2015</u>	\$ <u>65,006</u>
-----------------------	------------------

13. <u>12/31/2016</u>	\$ <u>65,006</u>
-----------------------	------------------

14. <u>12/31/2017</u>	\$ <u>65,006</u>
-----------------------	------------------

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: \_\_\_\_\_ \*

**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: \$ 3,011 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18				<u>978</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <b>978</b>	<b>21</b>

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

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

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39-3	hrs	\$			\$	27,879	\$	27,879	1		
2	Licensed Speech and Language Development Therapist	39-3	hrs					1,637		1,637	2		
3	Licensed Recreational Therapist		hrs								3		
4	Licensed Physical Therapist	39-3	hrs					84,386		84,386	4		
5	Physician Care		visits								5		
6	Dental Care		visits								6		
7	Work Related Program		hrs								7		
8	Habilitation		hrs								8		
9	Pharmacy	39-2	# of prescrpts					17,569		17,569	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10		
11	Academic Education		hrs								11		
12	Other (specify):										12		
13	Other (specify): <u>radiology,laboratory</u>							1,910		1,910	13		
14	TOTAL			\$			\$	115,812	\$	17,569	\$	133,381	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.

Facility Name & ID Number ARBA CARE CENTER OF COLFAX# 0052969Report Period Beginning: 10/01/2014Ending: 03/31/2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (43,160)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (13,662) )	1,030,693		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,064		7
8	Accounts Receivable (owners or related parties)	170,051		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	17,000		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,176,648	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	12,082		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	51,228		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	4,312		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 67,622	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,244,270	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 325,039	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	375,573		29
30	Accrued Salaries Payable	47,416		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,490		31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	58,759		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 822,477	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 822,477	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 421,793	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,244,270	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	186,793	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) <u>Capital Contr. During Year</u>	235,000	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 421,793	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 421,793	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,426,933	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,426,933	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	38,947	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 38,947	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	34	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 34	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>		26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,465,914	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	294,890	31
32	Health Care	391,486	32
33	General Administration	348,873	33
<b>B. Capital Expense</b>			
34	Ownership	53,840	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	133,381	35
36	Provider Participation Fee	56,651	36
<b>D. Other Expenses (specify):</b>			
37	<u>OUT-OF-PERIOD EXPENSES</u>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,279,121	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	186,793	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 186,793	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 724,755	44
45	Private Pay - Net Inpatient Revenue	234,989	45
46	Medicare - Net Inpatient Revenue	358,637	46
47	Other-(specify) <u>INSURANCE</u>	108,552	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,426,933	49

**\*\*TAX RETURN PREPARED ON CASH BASIS**

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

\*\* Does this agree with taxable income (loss) per Federal Income

Tax Return? NO\*\* 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 **ARBA CARE CENTER OF COLFAX**

# **0052969**

Report Period Beginning: **10/01/2014**

Ending: **03/31/2015**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,040	1,040	\$ 32,894	\$ 31.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,978	2,015	56,650	28.11	3
4	Licensed Practical Nurses	2,600	2,750	68,714	24.99	4
5	CNAs & Orderlies	11,900	12,000	139,398	11.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,452	1,452	26,005	17.91	8
9	Activity Director	1,040	1,040	17,330	16.66	9
10	Activity Assistants	1,000	1,008	11,194	11.11	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,040	1,040	15,565	14.97	13
14	Head Cook	3,000	3,075	35,976	11.70	14
15	Cook Helpers/Assistants	2,990	3,043	31,614	10.39	15
16	Dishwashers					16
17	Maintenance Workers	1,304	1,324	23,537	17.78	17
18	Housekeepers	4,289	4,322	46,589	10.78	18
19	Laundry	967	967	10,217	10.57	19
20	Administrator	1,040	1,040	41,213	39.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,705	1,745	33,154	19.00	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)	37,345	37,861	\$ 590,050 *	\$ 15.58	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 1,570	1-3	35
36	Medical Director	O	4,800	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,214	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,584		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
<b>KIM COLBROOK</b>	<b>ADMINISTRATOR</b>		\$ <b>41,213</b>	Workers' Compensation Insurance	\$ <b>23,529</b>	IDPH License Fee	\$		
	<b>ASST ADMIN</b>		<b>0</b>	Unemployment Compensation Insurance	<b>15,097</b>	Advertising: Employee Recruitment		<b>696</b>	
	<b>OTHER ADMIN</b>		<b>0</b>	FICA Taxes	<b>44,628</b>	Health Care Worker Background Check		<b>524</b>	
				Employee Health Insurance	<b>7,981</b>	(Indicate # of checks performed _____)			
				Employee Meals	<b>0</b>	<b>Patient Background Checks</b>		<b>0</b>	
				Illinois Municipal Retirement Fund (IMRF)*		<b>TRUST/FRANCHISE/CONTRIB/ETC</b>		<b>0</b>	
				<b>EMPLOYEE BENEFITS - OTHER</b>	<b>2,246</b>	<b>MARKETING/ADV/PROMO</b>		<b>1,555</b>	
				<b>EMPLOYEE PHYSICAL EXAMS</b>	<b>90</b>	<b>LICENSES/DUES/SUBSCRIPTIONS</b>		<b>2,804</b>	
				<b>PENSION/PROFIT SHARING PLANS</b>	<b>0</b>	<b>MGMT CO ALLOC</b>			
				<b>CHICAGO HEAD TAX</b>	<b>0</b>	<b>TRUST/FRANCHISE/CONTRIB/ETC</b>		<b>0</b>	
				<b>INSURANCE - EXECUTIVE LIFE</b>	<b>0</b>	Less: Public Relations Expense	(	<b>0</b> )	
				<b>INSURANCE - EXECUTIVE LIFE VI 21</b>	<b>0</b>	Non-allowable advertising		<b>(1,555)</b>	
						Yellow page advertising	(	<b>0</b> )	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <b>41,213</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <b>93,571</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$	<b>4,024</b>	
<b>(List each licensed administrator separately.)</b>									
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
Description				Description			Description		
Amount				Line #			Amount		
<b>ARBA HEALTHCARE</b>							Out-of-State Travel		
\$ <b>5,000</b>							\$		
<b>CRAIG FRANK</b>									
<b>15,000</b>							<b>In-State Travel</b>		
							<b>0</b>		
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>				<b>TOTAL</b>			<b>Seminar Expense</b>		
<b>(Attach a copy of any management service agreement)</b>									
\$ <b>20,000</b>				\$			<b>0</b>		
							<b>Entertainment Expense</b>		
							(		
							<b>0</b> )		
							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>		
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>							\$		
<b>(For legal fee disclosure, see page 39 of instructions)</b>									
\$ <b>68,259</b>									

\* Attach copy of IMRF notifications

\*\*See instructions.

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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number ARBA CARE CENTER OF COLFAX

# 0052969

Report Period Beginning: 10/01/2014

Ending: 03/31/2015

## 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?  
If YES, give association name and amount. NO
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,670 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 X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
ASTA CARE CENTER OF COLFAX, LLC 0051227 10/1/14
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 56,651  
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. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 5%
- 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? NO
- 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? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.