FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0005462

Facility Name: The Arthur Home

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

County: Moultrie

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Lashelle Plank **Telephone Number:** (217)-543-4551
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2015 to 8/31/2016 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)
(Title)

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Kevin Wellen, Director
(Firm Name & Address) CliftonLarsonAllen, 600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) (314)-925-4309 Fax # (314)-925-4350

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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	53	Skilled (SNF)	53	19,398	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	53	TOTALS	53	19,398	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	4,054	7,856	2,538	14,448	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,054	7,856	2,538	14,448	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.48%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 2,538

Medicare Intermediary Wisconsin Physician Services, Inc. (WPS)

IV. ACCOUNTING BASIS

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

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

Tax Year: 08/31/2016 Fiscal Year: 08/31/2016

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	210,201	232	12,768	223,201		223,201		223,201			1
2	Food Purchase		148,617		148,617		148,617	(8,541)	140,076			2
3	Housekeeping	101,554	12,305	1,166	115,025		115,025		115,025			3
4	Laundry	75,030	8,552		83,582		83,582		83,582			4
5	Heat and Other Utilities			43,273	43,273		43,273		43,273			5
6	Maintenance	67,962	17,278	60,356	145,596		145,596		145,596			6
7	Other (specify):*											7
8	TOTAL General Services	454,747	186,984	117,563	759,294		759,294	(8,541)	750,753			8
	B. Health Care and Programs											
9	Medical Director			12,250	12,250		12,250		12,250			9
10	Nursing and Medical Records	1,055,564	96,465	77,897	1,229,926		1,229,926	(19,469)	1,210,457			10
10a	Therapy			418,967	418,967		418,967		418,967			10a
11	Activities	53,393	2,354	5,745	61,492		61,492	(4,241)	57,251			11
12	Social Services	33,147	90		33,237		33,237		33,237			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,142,104	98,909	514,859	1,755,872		1,755,872	(23,710)	1,732,162			16
	C. General Administration											
17	Administrative	84,035			84,035		84,035		84,035			17
18	Directors Fees											18
19	Professional Services			35,322	35,322		35,322		35,322			19
20	Dues, Fees, Subscriptions & Promotions			11,854	11,854		11,854		11,854			20
21	Clerical & General Office Expenses	127,534	8,245	255,066	390,845		390,845	(148,594)	242,251			21
22	Employee Benefits & Payroll Taxes			248,925	248,925		248,925		248,925			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,950	22,950		22,950		22,950			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,451	55,451		55,451		55,451			26
27	Other (specify):*											27
28	TOTAL General Administration	211,569	8,245	629,568	849,382		849,382	(148,594)	700,788			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,808,420	294,138	1,261,990	3,364,548		3,364,548	(180,845)	3,183,703			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Arthur Home #0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			76,188	76,188		76,188		76,188			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,264	75,264		75,264		75,264			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			20,672	20,672		20,672	(20,672)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			172,124	172,124		172,124	(20,672)	151,452			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,187		149,187		149,187	(149,187)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,346	96,346		96,346		96,346			42
43	Other (specify):*	383,590		522,295	905,885		905,885	(905,885)				43
44	**TOTAL Special Cost Centers**	383,590	149,187	618,641	1,151,418		1,151,418	(1,055,072)	96,346			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,192,010	443,325	2,052,755	4,688,090		4,688,090	(1,256,589)	3,431,501			45

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,541)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,995)	21		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	(281)	21		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	(144,351)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page5A	(1,094,421)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,256,589)		$	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)	(1,440)	VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,440)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,258,029)		37

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

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

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

The Arthur Home

ID# 0005462

Report Period Beginning: 9/1/2015

Ending: 8/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Ray - Medicare Expense	$ (12,010)	39	1
2	Lab - Medicare Expense	(7,958)	39	2
3	Eberhardt Village, Inc. (Assisted Living) Expenses	(905,885)	43	3
4	Other Income/Expense	10,369	21	4
5	Transportation Income	(19,469)	10	5
6	Farm Land Rent	(1,394)	21	6
7	Activity Income	(4,241)	11	7
8	Advertising Expense	(2,955)	21	8
9	Other Taxes	(987)	21	9
10	Intercompany Rent	(20,672)	34	10
11				11
12	Oxygen Supply	(18,059)	39	12
13	Pharmacy - Medicare Expense	(111,160)	39	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,094,421)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arthur Home # 0005462 **Report Period Beginning:** 9/1/2015 **Ending:** 8/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,541)	0	0	0	0	0	0	0	0	0	0	(8,541)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,541)	0	0	0	0	0	0	0	0	0	0	(8,541)	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	(19,469)	0	0	0	0	0	0	0	0	0	0	(19,469)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,241)	0	0	0	0	0	0	0	0	0	0	(4,241)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(23,710)	0	0	0	0	0	0	0	0	0	0	(23,710)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(148,594)	0	0	0	0	0	0	0	0	0	0	(148,594)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(148,594)	0	0	0	0	0	0	0	0	0	0	(148,594)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(180,845)	0	0	0	0	0	0	0	0	0	0	(180,845)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arthur Home # 0005462 **Report Period Beginning:** 9/1/2015 **Ending:** 8/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(20,672)	0	0	0	0	0	0	0	0	0	0	(20,672)	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**	(20,672)	0	0	0	0	0	0	0	0	0	0	(20,672)	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	(149,187)	0	0	0	0	0	0	0	0	0	0	(149,187)	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):*	(905,885)	0	0	0	0	0	0	0	0	0	0	(905,885)	43
44	**TOTAL Special Cost Centers**	(1,055,072)	0	0	0	0	0	0	0	0	0	0	(1,055,072)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,256,589)	0	0	0	0	0	0	0	0	0	0	(1,256,589)	45

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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		Maintenance	$ 1,440	Henry Herschberger - Board Member	0.00%	$ 1,440	$	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			$ 1,440			$ 1,440	$ *	14

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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 The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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	First Mid-Illinois Bank		X	Real Estate Finance	$8,202.55	1/5/2015	$ 1,325,000	$ 1,282,387	1/5/2018	4.250%	$ 57,604	1
2	First Mid-Illinois Bank		X	Operating Loan	$3,073.76	3/1/2016	300,000	260,079	3/1/2026	4.250%	3,571	2
3	First Mid-Illinois Bank		X	Working Capital	None	12/18/2015	200,000	190,000	12/18/2016	4.500%	4,134	3
4	ONR Note		X	Working Capital	None	08/25/2016	72,539	72,539	08/25/2017	4.000%	242	4
5												5
	Working Capital											
6	Private Loans		X	Working Capital	None	6/13/2012	100,000	162,018	6/13/2013	4.000%	6,017	6
7	Greencroft LOC		X	Working Capital	None	10/26/2012	200,000	200,000	None	5.000%	1,793	7
8	SHF Note/Promissory Notes	X		Working Capital	None	8/25/2016	120,000	120,000	None	0.270%	1,903	8
9	TOTAL Facility Related				$11,276.31		$ 2,317,539	$ 2,287,023			$ 75,264	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,317,539	$ 2,287,023			$ 75,264	15

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arthur Home COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (217)-543-4551 FAX #: (217)-543-2278

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes on		$	$
2.	non-care assets. All costs are		$	$
3.	adjusted out of report		$	$
4.			$	$
5.	03-03-25-425-010	N PT SW 1/4 SE 1/4 Gibson	$ 637.00	$
6.	03-03-25-425-011	N PT SW 1/4 SE 1/4 Gibson Add	$ 86.00	$
7.	03-03-25-406-020	431 W Palmer Road	$ 64,194.00	$
8.	03-03-25-406-017	PT SW 1/4 SE 1/4	$ 288.00	$
9.	03-03-25-406-014	PT SW 1/4 SE 1/4	$ 3.00	$
10.	03-03-25-406-021	PT SW 1/4 SE 1/4	$ 4.00	$
		TOTALS	$ 65,212.00	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	152,469	1959	$ 50,084	1
2					2
3	TOTALS	152,469		$ 50,084	3

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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	25		1959	1959	$ 124,966	$	33	$	$	$ 124,966	4
5	28		1975	1975	308,252		33			308,252	5
6											6
7											7
8											8
	Improvement Type**										
9	1987 Fixed Assets			1987	99,897					99,897	9
10	1989 Fixed Assets			1989	4,907					4,907	10
11	1990 Fixed Assets			1990	43,501					43,501	11
12	1992 Fixed Assets			1992	43,861	1,136	25	1,136		43,239	12
13	1993 Fixed Assets			1993	14,164					14,164	13
14	1994 Fixed Assets			1994	3,832					3,832	14
15	1995 Fixed Assets			1995	42,675					42,675	15
16	1996 Fixed Assets			1996	7,427	287		287		7,406	16
17	1997 Fixed Assets			1997	45,493	918		918		45,176	17
18	1998 Fixed Assets			1998	23,587	1,164		1,164		21,349	18
19	1999 Fixed Assets			1999	705	35	20	35		605	19
20	2000 Fixed Assets			2000	1,805	20		20		1,737	20
21	2001 Fixed Assets			2001	8,851	339		339		7,240	21
22	2002 Fixed Assets			2002	28,509	1,425		1,425		20,111	22
23	2003 Fixed Assets			2003	2,653	177		177		2,255	23
24	2004 Fixed Assets			2004	13,501	450		450		12,133	24
25	2005 Fixed Assets			2005	63,018	2,720		2,720		42,251	25
26	2006 Fixed Assets			2006	7,798	310		310		6,269	26
27	2007 Fixed Assets			2007	20,696	1,654		1,654		15,089	27
28	2008 Fixed Assets			2008	20,290	1,936		1,936		16,183	28
29	2009 Fixed Assets			2009	32,440	2,151		2,151		16,301	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 The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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	Wall Paper - Hallways	2010	$ 2,000	$ -		$	$	$ 2,000	37
38	Front Sidewalk - Front Door	2010	628	63		63		392	38
39	Wallpaper ParkView	2010	2,654	265		265		1,637	39
40	Wallpapering-LakeView	2011	1,400	204		204		834	40
41	Wallpaper-LakeView	2011	2,043	140		140		1,059	41
42	Windows (8)Parkview	2011	2,760	184		184		1,012	42
43	BACK DOOR - Arthur Home	2011	3,257	326		326		1,737	43
44	AH Lock Rekeying - Arthur Home	2011	2,763	276		276		1,382	44
45	Plumbing - Basement	2011	3,677	736		736		3,677	45
46	Trees	2011	1,188	237		237		1,127	46
47	Panic Device	2012	890	178		178		1,068	47
48	Sconces - Hallways	2012	937	187		187		840	48
49	Room Remodel - Room 42	2012	975	195		195		866	49
50	Sprinkler System-Parkview	2012	19,870	1,987		1,987		8,941	50
51	Sprinklers Wiring	2012	507	101		101		456	51
52	Remodel Room Paint - Various Rooms	2012	558	-		-		558	52
53	Carpet - Room 21	2012	706	-		-		706	53
54	Fire Doors Between 40&50	2013	5,276	1,055		1,055		3,869	54
55	Floor Work - Hallway between 30 & 60	2013	685	95		95		685	55
56	Floor Work - Hallway between 30 & 60	2013	308	43		43		308	56
57	Relocate Dry Pendents - Crawl space	2013	3,637	505		505		3,637	57
58	Carpet - Room 35	2013	792	198		198		792	58
59	Carpet - Room 37	2013	1,109	277		277		1,109	59
60	Shower Room Floor	2014	3,198						60
61	S Tube	2015	935	468		468		468	61
62	Sewer Drain	2015	1,520	152		152		152	62
63	EV Building Transferred to Arthur (Net Impairment)	2015	6,453,958	30,861		30,861		30,865	63
64	Building Impairment							5,491,000	64
65	To Tie to FS								65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,481,059	$ 53,455		$ 53,455	$	$ 6,460,715	70

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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	$ 240,836	$ 18,295	$ 18,295	$	VAR	$ 111,963	71
72	Current Year Purchases	24,414	4,437	4,437		VAR	4,437	72
73	Fully Depreciated Assets	309,260				VAR	309,260	73
74	To Tie to FS							74
75	TOTALS	$ 574,510	$ 22,732	$ 22,732	$		$ 425,660	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	Resident Care	1991 Aerostar Van	1991	$ 15,110	$	$	$	5	$ 15,110	76
77	Resident Care	Handicap Bus	2001	45,103				5	45,103	77
78	Resident Care	2004 Toyota Sienna	2010	5,750				4	5,750	78
79	Resident Care	Van Converstion	2010	12,650				4	7,650	79
80	TOTALS			$ 78,613	$	$	$		$ 73,613	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)	$ 8,184,266	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 76,187	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 76,187	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)	$ 6,959,988	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	Assisted Living Land	$	$	$	86
87	Assisted Living Building	4,029	791	791	87
88	Assisted Living Grounds				88
89	Assisted Living Vehicles	13,400		13,400	89
90	Assisted Living Equipment	335,891	13,788	247,552	90
91	TOTALS	$ 353,320	$ 14,579	$ 261,743	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2015 Ending: 8/31/2016

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	2,265	$ 140,882	$	2,265	$ 140,882	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,796	106,267		1,796	106,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		2,757	171,818		2,757	171,818	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			$	6,818	$ 418,967	$	6,818	$ 418,967	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 The Arthur Home **#** 0005462 **Report Period Beginning:** 9/1/2015 **Ending:** 8/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 8/31/2016 **(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	$ 260,284	$	1
2	Cash-Patient Deposits	28,968		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 630,802)	1,001,917		3
4	Supply Inventory (priced at)	19,151		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,129		6
7	Other Prepaid Expenses	3,487		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Perpetual Trust	311,805		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,634,741	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	264,084		13
14	Buildings, at Historical Cost	7,175,648		14
15	Leasehold Improvements, at Historical Cost	309,440		15
16	Equipment, at Historical Cost	1,002,414		16
17	Accumulated Depreciation (book methods)	(7,221,730)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,529,856	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,164,597	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 587,771	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,772		28
29	Short-Term Notes Payable	875,643		29
30	Accrued Salaries Payable	165,809		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,075		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,134		32
33	Accrued Interest Payable	14,526		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Other Accrued Expenses	32,095		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,776,825	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,411,380		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Asset Retirement Obligation	89,555		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,500,935	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,277,760	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (113,163)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,164,597	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (164,473)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (164,473)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	51,310	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)**	$ 51,310	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)**	$ (113,163)	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	$ 3,774,402	1
2	Discounts and Allowances for all Levels	(922,601)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,851,801	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	484,676	6
7	Oxygen	9,708	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 494,384	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,541	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	144,000	16
17	Sale of Drugs	168,619	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,804	19
20	Radiology and X-Ray	3,994	20
21	Other Medical Services	18,703	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 349,661	23
	D. Non-Operating Revenue		
24	Contributions	27,405	24
25	Interest and Other Investment Income***	18	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,423	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Assisted Living Revenue**	994,042	28
28a	**Miscellaneous See Grouping Report IS28A Detail**	22,089	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,016,131	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,739,400	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	759,294	31
32	Health Care	1,755,872	32
33	General Administration	849,382	33
	B. Capital Expense		
34	Ownership	172,124	34
	C. Ancillary Expense		
35	Special Cost Centers	1,151,418	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,688,090	40
41	**Income before Income Taxes (line 30 minus line 40)****	51,310	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 51,310	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,169,438	44
45	Private Pay - Net Inpatient Revenue	842,074	45
46	Medicare - Net Inpatient Revenue	750,204	46
47	Other-(specify) **Medicare Advantage**	90,085	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,851,801	49

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

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

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

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

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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	1,938	2,196	$ 70,796	$ 32.24	1
2	Assistant Director of Nursing	1,921	1,998	52,797	26.42	2
3	Registered Nurses	1,362	1,448	36,042	24.89	3
4	Licensed Practical Nurses	14,057	14,994	327,609	21.85	4
5	CNAs & Orderlies	37,082	39,743	470,805	11.85	5
6	CNA Trainees					6
7	Licensed Therapist	3,391	3,924	52,787	13.45	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,844	2,037	29,483	14.47	9
10	Activity Assistants	2,173	2,406	23,910	9.94	10
11	Social Service Workers	2,160	2,295	33,147	14.44	11
12	Dietician					12
13	Food Service Supervisor	2,046	2,218	22,990	10.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,901	15,946	187,211	11.74	15
16	Dishwashers					16
17	Maintenance Workers	5,192	5,847	67,962	11.62	17
18	Housekeepers	7,879	8,637	101,554	11.76	18
19	Laundry	5,642	6,454	75,030	11.63	19
20	Administrator	2,252	2,454	84,035	34.24	20
21	Assistant Administrator					21
22	Other Administrative	7,144	8,048	127,534	15.85	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS/Quality Assu	1,732	2,033	44,728	22.00	32
33	Other(specify) Assisted Living	19,263	20,960	383,590	18.30	33
34	TOTAL (lines 1 - 33)	131,979	143,638	$ 2,192,010 *	$ 15.26	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		$ 9,190	1-3	35
36	Medical Director	Monthly	12,250	9-3	36
37	Medical Records Consultant	Monthly	3,509	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		591	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	Monthly	2,133	11-3	44
45	Social Service Consultant	Monthly	2,133	11-3	45
46	Other(specify) Dental Consultant	Monthly	1,080	10-3	46
47	Risk Management Consultant		3,810	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 34,696		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	33	$ 1,538	10-3	50
51	Licensed Practical Nurses	95	3,627	10-3	51
52	Certified Nurse Assistants/Aides	2,514	63,742	10-3	52
53	TOTAL (lines 50 - 52)	2,642	$ 68,907		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristi Day	Administrator	0	$ 84,035
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,035

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Polsinelli/Shughart,PC Greencroft	Legal	$ 3,295
Clifton Larson Allen, LLP	Accounting/Audit	26,582
Consolidated Services	Parcel Survey	783
Lender's Loan Title Work	Appraisal Fee	4,662
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 35,322

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,114
Unemployment Compensation Insurance	3,313
FICA Taxes	146,797
Employee Health Insurance	27,121
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	776
Pension Contribution	15,804
TOTAL (agree to Schedule V, line 22, col.8)	$ 248,925

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	7,981
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses Other	1,333
Dues	454
Subscriptions	96
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,854

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,440
Seminar Expense	15,510
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,950

**See instructions.

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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. **LSN $ / Leading Age $**

(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? **3-5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,107** 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. **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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **96,346**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,541**

(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? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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) Has a schedule for the legal fees reported on the cost report been provided by the facility? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees