

		FOR BHF USE					

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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.

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

<p>I. IDPH License ID Number: <u>0033043</u></p> <p>Facility Name: <u>NEW ATHENS HOME FOR THE AGED</u></p> <p>Address: <u>203 S JOHNSON ST</u> <u>NEW ATHENS</u> <u>62264</u> Number City Zip Code</p> <p>County: <u>ST CLAIR</u></p> <p>Telephone Number: <u>618-475-2550</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/1968</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Sara Archer</u> Telephone Number: <u>618-475-2550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Sara Archer</u> (Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td style="width: 20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>JEFFREY T. RENNER, CPA</u> (Firm Name & Address) <u>RENNER & ASSOCIATES, P.C. 13 PARK PL SUITE A SWANSEA IL 62226</u> (Telephone) <u>618-235-6522</u> Fax # <u>618-235-6588</u></td> </tr> </table> <p style="text-align: center;">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Sara Archer</u> (Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>JEFFREY T. RENNER, CPA</u> (Firm Name & Address) <u>RENNER & ASSOCIATES, P.C. 13 PARK PL SUITE A SWANSEA IL 62226</u> (Telephone) <u>618-235-6522</u> Fax # <u>618-235-6588</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Sara Archer</u> (Title) <u>ADMINISTRATOR</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>JEFFREY T. RENNER, CPA</u> (Firm Name & Address) <u>RENNER & ASSOCIATES, P.C. 13 PARK PL SUITE A SWANSEA IL 62226</u> (Telephone) <u>618-235-6522</u> Fax # <u>618-235-6588</u>							

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 4/18/07

	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	37	Skilled (SNF)	37	13,505	1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	53	TOTALS	53	19,345	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,299	1,299	8
9	SNF/PED					9
10	ICF	5,393	7,246		12,639	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,393	7,246	1,299	13,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.05%

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)

PODIATRY, MEALS, FLU SHOTS

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 01/01/1968

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 37 and days of care provided 1,299

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 123116 Fiscal Year: 12/31/2016

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

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/16 Ending: 12/31/16

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
	A. General Services										
1	Dietary	148,317	5,893		154,210	7,646	161,856		161,856		1
2	Food Purchase		95,632		95,632		95,632		95,632		2
3	Housekeeping	75,408	15,895		91,303		91,303		91,303		3
4	Laundry	65,294	22,124		87,418		87,418		87,418		4
5	Heat and Other Utilities			79,318	79,318		79,318		79,318		5
6	Maintenance	41,774	37,566		79,340		79,340		79,340		6
7	Other (specify):*										7
8	TOTAL General Services	330,793	177,110	79,318	587,221	7,646	594,867		594,867		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	752,718	223,052		975,770	1,406	977,176		977,176		10
10a	Therapy					59,274	59,274		59,274		10a
11	Activities	36,030	1,685		37,715		37,715		37,715		11
12	Social Services	22,811			22,811	3,636	26,447		26,447		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Care Plan Coordinato	35,091		152,526	187,617	(152,526)	35,091		35,091		15
16	TOTAL Health Care and Programs	846,650	224,737	152,526	1,223,913	(88,210)	1,135,703		1,135,703		16
	C. General Administration										
17	Administrative	58,846			58,846	80,564	139,410		139,410		17
18	Directors Fees										18
19	Professional Services			40,542	40,542		40,542		40,542		19
20	Dues, Fees, Subscriptions & Promotions			10,525	10,525		10,525		10,525		20
21	Clerical & General Office Expenses	26,412	20,283	7,963	54,658		54,658		54,658		21
22	Employee Benefits & Payroll Taxes			147,245	147,245		147,245		147,245		22
23	Inservice Training & Education			2,363	2,363		2,363		2,363		23
24	Travel and Seminar			3,196	3,196		3,196		3,196		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			59,575	59,575		59,575		59,575		26
27	Other (specify):* Bad Debt Expense			37,850	37,850		37,850	(37,850)			27
28	TOTAL General Administration	85,258	20,283	309,259	414,800	80,564	495,364	(37,850)	457,514		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,262,701	422,130	541,103	2,225,934		2,225,934	(37,850)	2,188,084		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 **NEW ATHENS HOME FOR THE AGED**

#0033043

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	
	D. Ownership											
30	Depreciation			60,917	60,917		60,917		60,917			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,988	24,988		24,988		24,988			32
33	Real Estate Taxes			7,694	7,694		7,694	(7,694)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			93,599	93,599		93,599	(7,694)	85,905			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,188	107,188		107,188		107,188			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			107,188	107,188		107,188		107,188			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,262,701	422,130	741,890	2,426,721		2,426,721	(45,544)	2,381,177			45

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

VI. ADJUSTMENT DETAIL

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

		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	37,850			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	7,694	33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 45,544		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 45,544		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

ID# 0033043

Report Period Beginning: 1/1/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED# 0033043

Report Period Beginning:

1/1/16

Ending:

12/31/16

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)	
	A. General Services													
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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/16 Ending: 12/31/16

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)	
	D. Ownership													
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	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

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
ILLINOIS SOUTH CONFERENCE OF THE UNITED CHURCH OF CHRIST	100					

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

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

Facility Name & ID Number

NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning:

1/1/16

Ending:

12/31/16

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 NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/16 Ending: 12/31/16

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									\$		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 NEW ATHENS HOME FOR THE AGED # 0033043 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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					\$	\$		\$	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

NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning:

1/1/16

Ending:

12/31/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	NATIONAL BANK			MORTGAGE	\$3,837.39	11/3/11	\$ 203,000	\$ 203,000		5.0000	\$ 7,570	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	THE VILLAGE BANK			WORKING CAPITAL LOC		1/7/14	150,000	149,489		6.0000	8,994	6								
7	NATIONAL BANK			WORKING CAPITAL LOC		1/7/14	200,000	100,000		4.0000	7,992	7								
8												8								
9	TOTAL Facility Related				\$3,837.39		\$ 553,000	\$ 452,489			\$ 24,556	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 553,000	\$ 452,489			\$ 24,556	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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2015 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.)		\$	7,694	2
3. Under or (over) accrual (line 2 minus line 1).		\$	7,694	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.		\$	7,694	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	7,038	8
	2012	7,148	9
	2013	7,154	10
	2014	6,813	11
	2015	7,381	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 NEW ATHENS HOME FOR THE AGED COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0033043

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

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)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 _____ 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 NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning:

1/1/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,230 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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include NURSING HOME, ADJACENT LOT, and TOTALS.

Facility Name & ID Number **NEW ATHENS HOME FOR THE AGED**# **0033043**

Report Period Beginning:

1/1/16

Ending:

12/31/16**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			1957	\$ 223,618	\$		\$	\$	\$ 223,618	4
5			1970	320,925					320,925	5
6			1979	53,990	1,350		1,350		50,615	6
7			1980	97,178	2,429		2,429		88,675	7
8			1986	72,596	1,815		1,815		55,354	8
	Improvement Type**									
9	GENERAL		1966	10,431					10,431	9
10	GENERAL		1967	6,088					6,088	10
11	GENERAL		1968	4,183					4,183	11
12	GENERAL		1972	6,897					6,897	12
13	GENERAL		1973	13,854					13,854	13
14	GENERAL		1974	4,682					4,682	14
15	GENERAL		1975	14,081	70		70		14,081	15
16	GENERAL		1976	21,994	550		550		21,994	16
17	GENERAL		1978	2,886	72		72		2,771	17
18	GENERAL		1982	4,197	105		105		3,620	18
19	GENERAL		1983	34,509	863		863		28,901	19
20	GENERAL		1984	26,999	675		675		21,937	20
21	GENERAL		1985	43,436	1,086		1,086		34,206	21
22	GENERAL		1987	12,434	311		311		9,170	22
23	GENERAL		1990	37,579	939		939		24,896	23
24	GENERAL		1991	128,213	3,205		3,205		81,736	24
25	GENERAL		1992	52,056	1,301		1,301		31,884	25
26	GENERAL		1993	2,807	70		70		1,649	26
27	GENERAL		1994	18,866	416		416		11,594	27
28	GENERAL		1995	4,122	106		106		2,272	28
29	FOUNDATION REPAIRS		1996	15,640	401		401		8,221	29
30	ARCHITECT FEES		1998	3,800						30
31	KITCHEN RENOVATIONS		2001	595,899	14,899		14,899		238,364	31
32	DINING ROOM RENOVATIONS		2002	44,811	1,120		1,120		16,244	32
33	DINING ROOM RENOVATIONS		2003	3,029	76		76		1,054	33
34	DAMPERS		2003	930	23		23		314	34
35	A/C UNITS		2003	3,968	198		198		2,025	35
36	ARCHITECT FEES		2005	4,400	110		110		1,228	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 **NEW ATHENS HOME FOR THE AGED**# **0033043**

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ROOF REPAIR	2005	\$ 1,800	\$ 180		\$ 180	\$	\$ 1,448	37
38	CONCRETE PAD	2006	16,700	418		418		4,314	38
39	HALL FLOORING	2006	3,952	99		99		1,013	39
40	NEW DECK & COURTYARD	2006	23,121	578		578		5,780	40
41	ENLARGE DOORWAY	2007	1,199	30		30		297	41
42	HOT WATER HEATER	2007	7,574	189		189		1,830	42
43	LIGHT FIXTURES	2007	548	27		27		219	43
44	LANDSCAPE	2007	2,408	120		120		1,104	44
45	CARPET	2007	1,406	94		94		756	45
46									46
47	LIGHT FIXTURES	2008	663	33		33		262	47
48	APARTMENT CARPET	2009	1,678	112		112		808	48
49	ROOF	2009	30,570	3,057		3,057		21,781	49
50	2 A/C UNITS	2009	1,113	74		74		529	50
51	4 A/C UNITS	2009	2,310	154		154		1,117	51
52	80 GALLON WATER HEATER	2010	5,980	150		150		1,022	52
53	HAND RAIL ON RAMP	2010	7,525	188		188		1,191	53
54	2 ELECTRIC PANELS	2010	3,375	84		84		520	54
55	SPRINKLER SYSTEM	2010	5,500	138		138		836	55
56	AC UNIT	2010	1,595	106		106		700	56
57	2 A/C UNITS	2010	1,303	87		87		557	57
58	DOOR CLOSERS	2010	727	48		48		307	58
59	3 A/C UNITS	2010	5,725	382		382		2,417	59
60	GENERATOR	2010	17,523	438		438		2,628	60
61	SPRINKLER SYSTEM	2011	113,782	2,845		2,845		15,645	61
62	AC UNIT	2011	3,850	257		257		1,454	62
63	AC UNIT	2011	598	40		40		219	63
64	AC UNIT	2011	7,104	474		474		2,565	64
65	SUNROOM WINDOWS	2011	2,625	66		66		334	65
66	WATER HEATER	2011	1,054	26		26		134	66
67	MINE SUBSIDENCE REPAIR	2012	13,200	330		330		1,595	67
68	DRYWALL	2012	1,300	33		33		157	68
69	REMODEL SUNROOM	2012	19,648	491		491		2,333	69
70	TOTAL (lines 4 thru 69)		\$ 2,198,554	\$ 43,538		\$ 43,538	\$	\$ 1,419,355	70

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

Facility Name & ID Number **NEW ATHENS HOME FOR THE AGED**

0033043

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,198,554	\$ 43,538		\$ 43,538	\$	\$ 1,419,355	1
2	HOT WATER HEATER	2012	6,899	172		172		805	2
3	6 A/C UNITS	2012	3,426	228		228		990	3
4	WATER HEATER	2012	6,641	166		166		720	4
5	WATER HEATER	2012	5,895	147		147		614	5
6	AC UNITS	2013	3,457	230		230		749	6
7	Architectural Fees	2014	2,250	225		225		600	7
8	Wheelchair ramp	2014	2,400	240		240		600	8
9	12 AC Units	2014	8,220	822		822		1,781	9
10	Roof Repair	2014	19,100	478		478		1,035	10
11	Knight Lockinvar Boiler/Expansion	2015	12,600	504		504		945	11
12	Condenser/Expansion Valve	2015	6,000	570		570		870	12
13	Soffit	2015	9,518	238		238		297	13
14	New Roof	2015	86,527	2,163		2,163		3,605	14
15	Concrete Work	2016	4,500	225		225		225	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	TOTAL (lines 1 thru 33)		\$ 2,375,987	\$ 49,946		\$ 49,946	\$	\$ 1,433,191	34

**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	\$ 109,490	\$ 10,109	\$ 10,109	\$		\$ 68,929	71
72	Current Year Purchases	8,616	862	862			862	72
73	Fully Depreciated Assets	311,803					311,803	73
74								74
75	TOTALS	\$ 429,909	\$ 10,971	\$ 10,971	\$		\$ 381,594	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	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,832,896	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,917	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 60,917	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,814,785	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	TOTALS	\$	\$	\$	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: NONE

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

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	\$ _____

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: \$ _____ 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 34,476	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	601,083		3
4	Supply Inventory (priced at)	12,499		4
5	Short-Term Investments	2,100		5
6	Prepaid Insurance	12,616		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 662,774	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,000		13
14	Buildings, at Historical Cost	2,629,697		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	429,909		16
17	Accumulated Depreciation (book methods)	(1,974,410)		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)	\$ 1,112,196	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,774,970	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 198,304	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,750		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,388		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,635		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,400		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current portion of LT debt	286,289		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 548,766	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	166,200		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 166,200	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 714,966	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,060,004	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,774,970	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,062,753	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,062,753	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,749)	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)	\$ (2,749)	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)	\$ 1,060,004	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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,110,327	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,110,327	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,851	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,851	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	281,520	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 281,520	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Rental Income	27,274	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,274	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,423,972	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	587,221	31
32	Health Care	1,223,913	32
33	General Administration	414,800	33
B. Capital Expense			
34	Ownership	93,599	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	107,188	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,426,721	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,749)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,749)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

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

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

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

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	1,968	2,080	\$ 68,000	\$ 32.69	1
2	Assistant Director of Nursing	1,914	2,026	38,036	18.77	2
3	Registered Nurses	1,853	1,853	41,277	22.28	3
4	Licensed Practical Nurses	17,498	18,340	330,958	18.05	4
5	CNAs & Orderlies	23,940	25,670	274,447	10.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,169	36,030	16.61	9
10	Activity Assistants					10
11	Social Service Workers	1,880	1,986	22,811	11.49	11
12	Dietician					12
13	Food Service Supervisor	1,678	1,922	31,215	16.24	13
14	Head Cook	5,936	6,770	58,970	8.71	14
15	Cook Helpers/Assistants	3,930	4,235	36,042	8.51	15
16	Dishwashers	2,165	2,330	22,090	9.48	16
17	Maintenance Workers	2,876	3,087	41,774	13.53	17
18	Housekeepers	7,262	7,689	75,408	9.81	18
19	Laundry	5,794	6,233	65,294	10.48	19
20	Administrator	1,992	2,080	58,846	28.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	826	826	15,705	19.01	23
24	Clerical	1,134	1,163	10,707	9.21	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) <u>Care Plan Coordinator</u>			35,091		33
34	TOTAL (lines 1 - 33)	84,686	90,459	\$ 1,262,701 *	\$ 13.96	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	145	\$ 7,646	1,5	35
36	Medical Director				36
37	Medical Records Consultant	4	240	10,5	37
38	Nurse Consultant				38
39	Pharmacist Consultant	33	1,166	10,5	39
40	Physical Therapy Consultant	445	26,485	10A,5	40
41	Occupational Therapy Consultant	298	23,179	10A,5	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	111	9,610	10A,5	43
44	Activity Consultant				44
45	Social Service Consultant	96	3,636	12,5	45
46	Other(specify) <u>Jamestown Management</u>		68,272	17,5	46
47	<u>Wescom</u>		5,292	17,5	47
48	<u>Wappooh Consulting</u>		7,000	17,5	48
49	TOTAL (lines 35 - 48)	1,132	\$ 152,526		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sara Archer	Administrator		\$ 58,846	Workers' Compensation Insurance	\$ 39,998	IDPH License Fee	\$	
				Unemployment Compensation Insurance	11,540	Advertising: Employee Recruitment	6,820	
				FICA Taxes	95,585	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	122	Patient Background Checks	3,705	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,846					
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				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Renner & Associates, P.C.	Audit		\$ 6,790			\$	Out-of-State Travel	\$
BKD LLC	Billing		30,652					
Hamilton Insurance	Capital Rate Audit		3,100				In-State Travel	
							Seminar Expense	3,196
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 40,542	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,196

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 107,188
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ 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? 0
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
 - 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? COMPILATION
Firm Name: RENNER & ASSOCIATES
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees