FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: Community Retirement, Inc. d/b/a 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: 1/01/1958

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 9/01/2016 to 8/31/2017 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 Ave, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4446 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 Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	19,345	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	19,345	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	3,966	7,817	2,962	14,745	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,966	7,817	2,962	14,745	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.22%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 1/01/1958

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 2,583

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: 8/31/2017 Fiscal Year: 8/31/2017

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

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthu # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	197,847	719	9,289	207,855		207,855		207,855			1
2	Food Purchase		107,894		107,894		107,894	(9,055)	98,839			2
3	Housekeeping	91,630	11,911	343	103,884		103,884		103,884			3
4	Laundry	61,510	99,240		160,750		160,750		160,750			4
5	Heat and Other Utilities			35,675	35,675		35,675		35,675			5
6	Maintenance	65,857	32,312	95,004	193,173		193,173		193,173			6
7	Other (specify):*											7
8	**TOTAL General Services**	416,844	252,076	140,311	809,231		809,231	(9,055)	800,176			8
	B. Health Care and Programs											
9	Medical Director			12,800	12,800		12,800		12,800			9
10	Nursing and Medical Records	1,174,918	81,977	93,485	1,350,380		1,350,380	(12,664)	1,337,716			10
10a	Therapy											10a
11	Activities	59,080	2,467	5,241	66,788		66,788	(6,831)	59,957			11
12	Social Services	43,114	119		43,233		43,233		43,233			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,277,112	84,563	111,526	1,473,201		1,473,201	(19,495)	1,453,706			16
	C. General Administration											
17	Administrative	90,691			90,691		90,691		90,691			17
18	Directors Fees											18
19	Professional Services			83,376	83,376		83,376		83,376			19
20	Dues, Fees, Subscriptions & Promotions			6,733	6,733		6,733		6,733			20
21	Clerical & General Office Expenses	147,796	7,781	397,198	552,775		552,775	(325,564)	227,211			21
22	Employee Benefits & Payroll Taxes			270,372	270,372		270,372		270,372			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,227	16,227		16,227		16,227			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,363	48,363		48,363		48,363			26
27	Other (specify):*											27
28	**TOTAL General Administration**	238,487	7,781	822,269	1,068,537		1,068,537	(325,564)	742,973			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,932,443	344,420	1,074,106	3,350,969		3,350,969	(354,114)	2,996,855			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 Community Retirement, Inc. d/b/a The Arthur Home #0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			83,948	83,948		83,948		83,948			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,496	93,496		93,496		93,496			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			198,116	198,116		198,116	(20,672)	177,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,042	435,246	537,288		537,288		537,288			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,494	96,494		96,494		96,494			42
43	Other (specify):* Assisted Living	455,909		556,583	1,012,492		1,012,492	(1,012,492)				43
44	TOTAL Special Cost Centers	455,909	102,042	1,088,323	1,646,274		1,646,274	(1,012,492)	633,782			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,388,352	446,462	2,360,545	5,195,359		5,195,359	(1,387,278)	3,808,081			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 Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	(9,055)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(812)	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	(160,281)	21		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	(160,266)	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 Page 5A	(1,056,864)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,387,278)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,387,278)		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

STATE OF ILLINOIS

Community Retirement, Inc. d/b/a The Arthur Home

ID# 0005462

Report Period Beginning: 9/01/2016

Ending: 8/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Income	$ (12,664)	10	1
2	Activity Income	(6,831)	11	2
3	Other Income/Expense	82	21	3
4	Farm Land Rent	(1,204)	21	4
5	Advertising Expense	(2,420)	21	5
6	Other Taxes	(663)	21	6
7	Intercompany Rent	(20,672)	34	7
8	Eberhardt Village, Inc. (Assisted Living) Expenses	(1,012,492)	43	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**	(1,056,864)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home **#** 0005462 **Report Period Beginning:** 9/01/2016 **Ending:** 8/31/2017

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	(9,055)	0	0	0	0	0	0	0	0	0	0	(9,055)	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**	(9,055)	0	0	0	0	0	0	0	0	0	0	(9,055)	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	(12,664)	0	0	0	0	0	0	0	0	0	0	(12,664)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(6,831)	0	0	0	0	0	0	0	0	0	0	(6,831)	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**	(19,495)	0	0	0	0	0	0	0	0	0	0	(19,495)	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	(325,564)	0	0	0	0	0	0	0	0	0	0	(325,564)	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**	(325,564)	0	0	0	0	0	0	0	0	0	0	(325,564)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(354,114)	0	0	0	0	0	0	0	0	0	0	(354,114)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Community Retirement, Inc. d/b/a The Arthur Home** **# 0005462** **Report Period Beginning: 9/01/2016** **Ending: 8/31/2017**

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	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):*	(1,012,492)	0	0	0	0	0	0	0	0	0	0	(1,012,492)	43
44	**TOTAL Special Cost Centers**	(1,012,492)	0	0	0	0	0	0	0	0	0	0	(1,012,492)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,387,278)	0	0	0	0	0	0	0	0	0	0	(1,387,278)	45

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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. [X] 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	$ 720	Henry Herschberger - Board Member	0.00%	$ 720	$	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			$ 720			$ 720	$ *	14

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

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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 Community Retirement, Inc. d/b/a The Arth # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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 Community Retirement, Inc. d/b/a The Arthu # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	1/05/15	$ 1,325,000	$ 1,239,911	1/01/18	4.2500	$ 54,737	1
2	First Mid-Illinois Bank		X	Operating Loan	$3,073.76	3/01/16	300,000	234,419	3/01/26	4.2500	10,508	2
3	First Mid-Illinois Bank		X	Working Capital	None	12/18/15	200,000	190,000	12/18/17	5.2500	8,075	3
4	First Mid-Illinois Bank		X	Eberhardt IL Construction	None	3/29/17	400,000	181,851	3/29/18	4.7500	1,800	4
5	ONR Note		X	Working Capital	None	8/25/16	72,539		8/25/17	4.0000	1,451	5
	Working Capital											
6	Private Loans		X	Working Capital	None	6/13/12	100,000	168,019	6/13/13	4.0000	6,601	6
7	Greencroft LOC		X	Working Capital	None	10/26/12	200,000	200,000	None	6.2500	10,000	7
8	SHF Note/Promissory Note	X		Working Capital	None	8/25/16	120,000	120,000	None	0.2700	324	8
9	TOTAL Facility Related				$11,276.31		$ 2,717,539	$ 2,334,200			$ 93,496	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,717,539	$ 2,334,200			$ 93,496	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 Community Retirement, Inc. d/b/a The Arthur Home **#** 0005462 **Report Period Beginning:** 9/01/2016 **Ending:** 8/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Community Retirement, Inc. d/b/a The Arthur Home COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT Lashelle Plank

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes on		$	$
2.	non-care assets. All costs are		$	$
3.	adjusted out of report.		$	$
4.			$	$
5.	03-03-25-406-014	PT SW 1/4 SE 1/4	$ 3.00	$
6.	03-03-25-406-017	PT SW 1/4 SE 1/4	$ 301.86	$
7.	03-03-25-406-020	431 W Palmer Road	$ 65,891.64	$
8.	03-03-25-406-021	PT SW 1/4 SE 1/4	$ 3.96	$
9.	03-03-25-425-010	N PT SW 1/4 SE 1/4 Gibson	$ 654.26	$
10.	03-03-25-425-011	N PT SW 1/4 SE 1/4 Gibson Add	$ 91.72	$
		TOTALS	$ 66,946.44	$

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	$ 264,084	1
2					2
3	TOTALS	152,469		$ 264,084	3

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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		Various			99,897	9
10	1989 Fixed Assets			1989	4,907		Various			4,907	10
11	1990 Fixed Assets			1990	43,501		Various			43,501	11
12	1992 Fixed Assets			1992	39,028	622	Various	622		39,028	12
13	1993 Fixed Assets			1993	10,165		Various			10,165	13
14	1994 Fixed Assets			1994	12,664		Various			12,664	14
15	1995 Fixed Assets			1995	42,675		Various			42,675	15
16	1996 Fixed Assets			1996	4,283		Various			4,283	16
17	1997 Fixed Assets			1997	48,637	337	Various	337		48,637	17
18	1998 Fixed Assets			1998	21,991	1,100	Various	1,100		21,315	18
19	1999 Fixed Assets			1999	1,817	75	Various	75		1,403	19
20	2000 Fixed Assets			2000	2,289	44	Various	44		2,191	20
21	2001 Fixed Assets			2001	8,851	339	Various	339		7,579	21
22	2002 Fixed Assets			2002	28,509	1,425	Various	1,425		21,536	22
23	2004 Fixed Assets			2004	11,827	457	Various	457		11,069	23
24	2005 Fixed Assets			2005	67,345	2,889	Various	2,889		48,916	24
25	2006 Fixed Assets			2006	5,518	37	Various	37		5,194	25
26	2007 Fixed Assets			2007	17,576	1,076	Various	1,076		12,551	26
27	2008 Fixed Assets			2008	6,477,896	33,227	Various	33,227		5,572,764	27
28	2009 Fixed Assets			2009	28,837	1,745	Various	1,745		14,917	28
29	2010 Fixed Assets			2010	10,638	847	Various	847		9,487	29
30	2011 Fixed Assets			2011	9,460	854	Various	854		5,497	30
31	2012 Fixed Assets			2012	32,071	2,592	Various	2,592		22,025	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 Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	Fire Doors Between 40&50	2013	$ 5,276	$ 1,055	5	$ 1,055	$	$ 4,924	37
38	Floor Work - Hallway between 30 & 60	2013	308	43	3	43		351	38
39	Floor Work - Hallway between 30 & 60	2013	685	95	3	95		780	39
40	LCD Display	2013	816	-	3			816	40
41	Relocate Dry Pendents - Crawl space	2013	3,637	505	3	505		4,142	41
42	Carpet - Room 35	2013	792	198	3	198		990	42
43	Carpet - Room 37	2013	1,109	277	3	277		1,386	43
44	Parkview Remodel	2014	1,337	134	10	134		412	44
45	Doors and Frames	2014	3,782	252	15	252		756	45
46	Shower Room Floor	2015	1,861	186	10	186		532	46
47	Part S Tube Lakeview	2016	935	468	2	468		935	47
48	Replace Part of Main Sewer Drain	2016	1,520	152	10	152		304	48
49	Activity Room Flooring	2017	3,680	77	20	77		77	49
50	Activity Room Floor	2017	766	32	10	32		32	50
51	Intercom Band B Glass	2017	1,276	231	4	231		231	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,491,380	$ 51,371		$ 51,371	$	$ 6,512,087	70

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

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Hom # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	$ 243,666	$ 28,630	$ 28,630	$	VARIOUS	$ 125,214	71
72	Current Year Purchases	7,966	929	929			929	72
73	Fully Depreciated Assets	330,844	1,769	1,769			330,844	73
74								74
75	TOTALS	$ 582,476	$ 31,328	$ 31,328	$		$ 456,987	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 & Van	2010	13,400				4	13,400	78
79	Resident Care	2004 Lincoln	2016	5,000	1,249	1,249		4	1,249	79
80	TOTALS			$ 78,613	$ 1,249	$ 1,249	$		$ 74,862	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)	$ 8,416,553	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,948	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,948	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)	$ 7,043,936	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 Building	$ 7,722	$ 643	$ 1,434	86
87	Assisted Living Vehicles	13,400		13,400	87
88	Assisted Living Equipment	373,262	22,404	269,956	88
89					89
90					90
91	TOTALS	$ 394,384	$ 23,047	$ 284,790	91

G. Construction-in-Progress

	Description	Cost	
92	Independent Living	$ 253,005	92
93			93
94			94
95		$ 253,005	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 Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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 Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	39-3	hrs	$	2,243	$ 136,087	$	2,243	$ 136,087	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		1,684	96,057		1,684	96,057	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		2,693	179,687		2,693	179,687	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			86,909			86,909	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab/Xray/Oxygen	39-3/39-2				38,548			38,548	12
13	Other (specify):									13
14	TOTAL			$	6,620	$ 537,288	$	6,620	$ 537,288	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 **Report Period Beginning:** 9/01/2016 **Ending:** 8/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 8/31/2017 (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	$ 177,172	$	1
2	Cash-Patient Deposits	29,093		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 730,000)	770,267		3
4	Supply Inventory (priced at)	29,383		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,360		6
7	Other Prepaid Expenses	9,343		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Perpetual Trust Receivable	305,815		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,336,433	$	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	7,189,662		14
15	Leasehold Improvements, at Historical Cost	309,440		15
16	Equipment, at Historical Cost	1,047,751		16
17	Accumulated Depreciation (book methods)	(7,328,726)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	253,005		22
23	Other(specify): Beneficial Interest in Estate	1,421,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,156,216	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,492,649	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 595,189	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,706		28
29	Short-Term Notes Payable	786,540		29
30	Accrued Salaries Payable	198,974		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,009		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,892		32
33	Accrued Interest Payable	13,179		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accruals - See Attachment	149,718		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,842,207	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,547,660		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Asset Retirement Obligation	94,032		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,641,692	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,483,899	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,008,750	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,492,649	$	48

***(See instructions.)**

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home **#** 0005462 **Report Period Beginning:** 9/01/2016 **Ending:** 8/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (113,163)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (113,163)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,121,913	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)**	$ 1,121,913	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)**	$ 1,008,750	24 *

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

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Hon # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	$ 3,832,554	1
2	Discounts and Allowances for all Levels	(878,617)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,953,937	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	490,166	6
7	Oxygen	8,973	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 499,139	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	9,055	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	144,000	16
17	Sale of Drugs	130,142	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,678	19
20	Radiology and X-Ray	5,026	20
21	Other Medical Services	5,869	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 300,770	23
	D. Non-Operating Revenue		
24	Contributions	1,454,112	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,454,112	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Assisted Living Revenue	1,094,687	28
28a	Misc. (See Grouping Report IS28A Detail)	14,627	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,109,314	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,317,272	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	809,231	31
32	Health Care	1,473,201	32
33	General Administration	1,068,537	33
	B. Capital Expense		
34	Ownership	198,116	34
	C. Ancillary Expense		
35	Special Cost Centers	1,646,274	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)***	$ 5,195,359	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,121,913	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,121,913	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 468,873	44
45	Private Pay - Net Inpatient Revenue	1,606,548	45
46	Medicare - Net Inpatient Revenue	859,048	46
47	Other-(specify) Medicare Advantage	19,468	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,953,937	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.**

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

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	1,994	2,172	$ 71,258	$ 32.81	1
2	Assistant Director of Nursing	1,384	1,873	48,363	25.82	2
3	Registered Nurses	4,508	4,717	133,722	28.35	3
4	Licensed Practical Nurses	10,928	12,051	277,138	23.00	4
5	CNAs & Orderlies	45,240	48,457	595,560	12.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,775	2,001	33,891	16.94	9
10	Activity Assistants	1,992	2,098	25,189	12.01	10
11	Social Service Workers	2,542	2,925	43,114	14.74	11
12	Dietician					12
13	Food Service Supervisor	1,650	1,782	27,111	15.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,888	16,724	170,736	10.21	15
16	Dishwashers					16
17	Maintenance Workers	3,651	3,930	65,857	16.76	17
18	Housekeepers	6,591	7,357	91,630	12.45	18
19	Laundry	4,719	5,365	61,510	11.47	19
20	Administrator	2,131	2,349	90,691	38.61	20
21	Assistant Administrator					21
22	Other Administrative	7,326	8,120	147,796	18.20	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	1,714	1,929	48,877	25.34	32
33	Other(specify) Assisted Living	30,266	32,153	455,909	14.18	33
34	TOTAL (lines 1 - 33)	144,299	156,003	$ 2,388,352 *	$ 15.31	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	Monthly	$ 5,347	1-3	35
36	Medical Director	Monthly	12,800	9-3	36
37	Medical Records Consultant	Monthly	546	10-3	37
38	Nurse Consultant	Monthly	5,817	10-3	38
39	Pharmacist Consultant				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	2,043	11-3	44
45	Social Service Consultant	Monthly	2,043	11-3	45
46	Other(specify) Dental Consultant	Monthly	1,320	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,916		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	149	$ 7,854	10-3	50
51	Licensed Practical Nurses	285	12,215	10-3	51
52	Certified Nurse Assistants/Aides	2,881	73,417	10-3	52
53	TOTAL (lines 50 - 52)	3,315	$ 93,486		53

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 Report Period Beginning: 9/01/2016 Ending: 8/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristina Kerst-Day	Administrator	0	$ 67,572
Deborah Kluge	Administrator	0	20,448
Tom Stephenson	Administrator	0	2,671
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,691

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
CliftonLarsonAllen, LLP	Audit/Tax/Cost Reports	$ 26,480
Polsinelli Shughart, PC	Legal Fees	23,936
Duane Morris, LLP	Annual Survey	32,960
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 83,376

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,526
Unemployment Compensation Insurance	11,316
FICA Taxes	147,122
Employee Health Insurance	34,843
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	2,347
Pension Contribution	16,218
TOTAL (agree to Schedule V, line 22, col.8)	$ 270,372

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,180
Advertising: Employee Recruitment	1,262
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues	3,994
Subscriptions	297
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,733

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,745
Seminar Expense	11,482
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,227

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Community Retirement, Inc. d/b/a The Arthur Home # 0005462 **Report Period Beginning:** 9/01/2016 **Ending:** 8/31/2017

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. **Leading Age IL, $3,311**

(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? **11**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,940** 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. $ **96,494**
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. $ **9,055**

(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