FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0023382

Facility Name: Eden Village Care Center

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

County: Madison

Telephone Number: 618-288-0514 **Fax #** 618-288-0206

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Dennis Ulrich **Telephone Number:** 618-656-1206
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2017 to 12/31/2017 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) Ron Hassler
(Title) Director of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Dennis Ulrich, CPA, Principal
(Firm Name & Address) Scheffel Boyle, 143 N Kansas St Edwardsville, IL 62025
(Telephone) 618-656-1206 Fax # 618-656-3536

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	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	8,427	19,494	4,823	32,744	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,427	19,494	4,823	32,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.09%

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)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/14/1979

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 3,153

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	421,057	75,125	19,077	515,259		515,259	(181,329)	333,930			1
2	Food Purchase		552,199		552,199		552,199	(252,617)	299,582			2
3	Housekeeping	214,321	83,558		297,879		297,879	(106,564)	191,315			3
4	Laundry	96,289	9,284		105,573		105,573	(42,036)	63,537			4
5	Heat and Other Utilities			581,460	581,460		581,460	(480,920)	100,540			5
6	Maintenance	200,212	800	430,869	631,881		631,881	(404,957)	226,924			6
7	Other (specify):*											7
8	TOTAL General Services	931,879	720,966	1,031,406	2,684,251		2,684,251	(1,468,423)	1,215,828			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	2,335,648	166,776	272,522	2,774,946		2,774,946	(61,833)	2,713,113			10
10a	Therapy	#NAME?	1,512	564,112	#NAME?		#NAME?		#NAME?			10a
11	Activities	564,828	8,199	6,538	579,565		579,565	(470,867)	108,698			11
12	Social Services	83,969	2,021	6,608	92,598		92,598		92,598			12
13	CNA Training											13
14	Program Transportation	37,971	2,589	2,601	43,161		43,161	(27,313)	15,848			14
15	Other (specify):* Seniors N Motion	22,065	213		22,278		22,278	(22,278)				15
16	TOTAL Health Care and Programs	#NAME?	181,310	869,181	#NAME?		#NAME?	(582,291)	#NAME?			16
	C. General Administration											
17	Administrative	160,372	1,034	695,860	857,266		857,266	(713,193)	144,073			17
18	Directors Fees											18
19	Professional Services			48,096	48,096		48,096		48,096			19
20	Dues, Fees, Subscriptions & Promotions			73,211	73,211		73,211	(46,785)	26,426			20
21	Clerical & General Office Expenses	260,620	45,527	133,705	439,852		439,852	(240,771)	199,081			21
22	Employee Benefits & Payroll Taxes			1,063,335	1,063,335		1,063,335	(221,551)	841,784			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,470	10,470		10,470	(10,470)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			288,000	288,000		288,000	(238,202)	49,798			26
27	Other (specify):* Supplies & Mtg/Development		3,824	9,387	13,211		13,211	(13,211)				27
28	TOTAL General Administration	420,992	50,385	2,322,064	2,793,441		2,793,441	(1,484,183)	1,309,258			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	#NAME?	952,661	4,222,651	#NAME?		#NAME?	(3,534,897)	#NAME?			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eden Village Care Center #0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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			151,419	151,419		151,419		151,419			30
31	Amortization of Pre-Op. & Org.			28,272	28,272		28,272		28,272			31
32	Interest			1,114,329	1,114,329		1,114,329	(1,112,975)	1,354			32
33	Real Estate Taxes			365,094	365,094		365,094	(365,094)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,659,114	1,659,114		1,659,114	(1,478,069)	181,045			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			123,031	123,031		123,031		123,031			39
40	Barber and Beauty Shops	47,604	1,941		49,545		49,545	(24,342)	25,203			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,188	246,188		246,188		246,188			42
43	Other (specify):* AL/Retirement Center			766,608	766,608		766,608	(766,608)				43
44	TOTAL Special Cost Centers	47,604	1,941	1,135,827	1,185,372		1,185,372	(790,950)	394,422			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	#NAME?	954,602	7,017,592	#NAME?		#NAME?	(5,803,916)	#NAME?			45

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	(22,278)	15		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(28,868)	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	(31,728)	32		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	(670,767)	17		24
25	Fund Raising, Advertising and Promotional	(46,785)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (800,426)		$	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))**	$ (800,426)		37

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

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

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

Eden Village Care Center

ID# 0023382

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RC-Dietary	$ (181,329)	1	1
2	RC-Food	(223,749)	2	2
3	RC-Housekeeping	(106,564)	3	3
4	RC-Laundry	(42,036)	4	4
5	RC-Heat & Utilities	(480,920)	5	5
6	RC-Maintenance	(375,924)	6	6
7	RC-Program Transportation	(22,175)	14	7
8	RC-Administrative	(42,426)	17	8
9	RC-Clerical & Office	(220,445)	21	9
10	RC-Employee Benefits/PR Taxes	(221,551)	22	10
11	RC-Insurance	(238,202)	26	11
12	RC-Direct Expenses (Depreciation)	(730,855)	43	12
13	RC-Activities Salaries	(470,867)	11	13
14	RC-Receptionist	(61,833)	10	14
15	Real Estate Taxes on RC	(365,094)	33	15
16	Marketing/Development Salaries	(13,211)	27	16
17	Lab, Xray, Ambulance services	(35,753)	43	17
18	RC-Interest Expeense on RC building	(1,081,247)	32	18
19	RC-Barber & Beauty	(24,342)	40	19
20	Other Revenue - Personal Purchases Misc.	(1,750)	21	20
21	Other Revenue - Transportation	(5,138)	14	21
22	Other Revenue - Senior TV	(29,033)	6	22
23	Other Revenue - Internet Purchases	(4,842)	21	23
24	Other Revenue - Phone Revenue CC Residents	(13,734)	21	24
25	Travel & Seminar	(10,470)	24	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**	(5,003,490)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(181,329)	0	0	0	0	0	0	0	0	0	0	(181,329)	1
2	Food Purchase	(252,617)	0	0	0	0	0	0	0	0	0	0	(252,617)	2
3	Housekeeping	(106,564)	0	0	0	0	0	0	0	0	0	0	(106,564)	3
4	Laundry	(42,036)	0	0	0	0	0	0	0	0	0	0	(42,036)	4
5	Heat and Other Utilities	(480,920)	0	0	0	0	0	0	0	0	0	0	(480,920)	5
6	Maintenance	(404,957)	0	0	0	0	0	0	0	0	0	0	(404,957)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,468,423)	0	0	0	0	0	0	0	0	0	0	(1,468,423)	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	(61,833)	0	0	0	0	0	0	0	0	0	0	(61,833)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(470,867)	0	0	0	0	0	0	0	0	0	0	(470,867)	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	(27,313)	0	0	0	0	0	0	0	0	0	0	(27,313)	14
15	Other (specify):*	(22,278)	0	0	0	0	0	0	0	0	0	0	(22,278)	15
16	**TOTAL Health Care and Programs**	(582,291)	0	0	0	0	0	0	0	0	0	0	(582,291)	16
	C. General Administration													
17	Administrative	(713,193)	0	0	0	0	0	0	0	0	0	0	(713,193)	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	(46,785)	0	0	0	0	0	0	0	0	0	0	(46,785)	20
21	Clerical & General Office Expenses	(240,771)	0	0	0	0	0	0	0	0	0	0	(240,771)	21
22	Employee Benefits & Payroll Taxes	(221,551)	0	0	0	0	0	0	0	0	0	0	(221,551)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(10,470)	0	0	0	0	0	0	0	0	0	0	(10,470)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(238,202)	0	0	0	0	0	0	0	0	0	0	(238,202)	26
27	Other (specify):*	(13,211)	0	0	0	0	0	0	0	0	0	0	(13,211)	27
28	**TOTAL General Administration**	(1,484,183)	0	0	0	0	0	0	0	0	0	0	(1,484,183)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,534,897)	0	0	0	0	0	0	0	0	0	0	(3,534,897)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(1,112,975)	0	0	0	0	0	0	0	0	0	0	(1,112,975)	32
33	Real Estate Taxes	(365,094)	0	0	0	0	0	0	0	0	0	0	(365,094)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,478,069)	0	0	0	0	0	0	0	0	0	0	(1,478,069)	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	(24,342)	0	0	0	0	0	0	0	0	0	0	(24,342)	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):*	(766,608)	0	0	0	0	0	0	0	0	0	0	(766,608)	43
44	**TOTAL Special Cost Centers**	(790,950)	0	0	0	0	0	0	0	0	0	0	(790,950)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(5,803,916)	0	0	0	0	0	0	0	0	0	0	(5,803,916)	45

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. [ ] YES [X] NO

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

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

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Rick Neuhaus	BOD						1
2	Dr. Max Eakin	BOD						2
3	Ted Eilerman	BOD						3
4	Janet Foehrkolb	BOD						4
5	Charlotte Frisbie	BOD						5
6	Jamie Henderson	BOD						6
7	Pam Heepke	BOD						7
8	Cale Henke	BOD						8
9	Dan Highlander	BOD						9
10	John Roberts	BOD						10
11	Don Sullivan	BOD						11
12	Yoko Mogi-Hein	BOD						12
13	Michelle Weber	BOD						13
14	Barry Wilson	BOD						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Series 2006 Revenue Bonds		X	Construction & Equipment		12/1/2006	$ 22,390,000	$ 17,830,000	2/1/2036	5.00-5.85	$ 1,083,478	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Bank of Edwardsville		X	Operations Line of Credit		8/11/2008	1,050,000	565,000			33,082	6
7												7
8												8
9	TOTAL Facility Related						$ 23,440,000	$ 18,395,000			$ 1,116,560	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 23,440,000	$ 18,395,000			$ 1,116,560	15

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

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

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

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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.**	$	338,216	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.)	$	345,197	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,981	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	358,113	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.	$	365,094	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012	400,488	8
2013	322,719	9
2014	327,229	10
2015	338,490	11
2016	345,200	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 Eden Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023382

CONTACT PERSON REGARDING THIS REPORT Ron Hassler

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

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

Enter the tax index number and real estate tax assessed for 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.	14-2-15-26-02-202-096	Cottonwood Trace PT Lot 3	$ 113.44	$
2.	14-1-15-26-02-202-098.001	NE/C NE	$ 64.64	$
3.	14-2-15-26-02-202-101	Cottonwood Trace - First Add LT PT	$ 1,415.08	$
4.	14-2-15-26-02-202-097	Cottonwood Trace PT Lot 2	$ 10,130.24	$
5.	14-2-15-26-02-202-165	Eden Village Subd 1st Addn Lot 1	$ 64,576.76	$
6.	14-2-15-26-02-202-100	Cottonwood Trace First Add PT Lots	$ 268,896.72	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 345,196.88	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,924 B. General Construction Type: Exterior Brick Frame Steel 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).

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land - SNF		1979	$ 166,295	1
2					2
3	TOTALS			$ 166,295	3

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	128		1979	1979	$ 2,008,520	$	30	$	$	$ 2,008,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Fixed Assets			1979	63,646		Various			63,646	9
10	1985 Fixed Assets			1985	28,768		Various			28,768	10
11	1989 Fixed Assets			1989	21,453		Various			21,453	11
12	1990 Fixed Assets			1990	34,575	1,152	Various	1,152		31,501	12
13	1991 Fixed Assets			1991	20,835		Various			20,835	13
14	1992 Fixed Assets			1992	106,730	3,494	Various	3,494		106,730	14
15	1993 Fixed Assets			1993	68,267	1,729	Various	1,729		66,839	15
16	1994 Fixed Assets			1994	42,035	750	Various	750		41,160	16
17	1995 Fixed Assets			1995	90,923		Various			90,923	17
18	1996 Fixed Assets			1996	64,116		Various			64,116	18
19	1997 Fixed Assets			1997	6,000	119	Various	119		6,000	19
20	1998 Fixed Assets			1998	1,632,945	39,650	Various	39,650		880,649	20
21	1999 Fixed Assets			1999	620,363	12,648	Various	12,648		349,748	21
22	2000 Fixed Assets			2000	31,137	487	Various	487		24,420	22
23	2001 Fixed Assets			2001	59,749		Various			59,749	23
24	2002 Fixed Assets			2002	9,200	368	Various	368		5,562	24
25	2003 Fixed Assets			2003	9,961	259	Various	259		7,806	25
26	2004 Fixed Assets			2004	23,265	959	Various	959		13,939	26
27	2005 Fixed Assets			2005	178,706	1,170	Various	1,170		164,375	27
28	2006 Fixed Assets			2006	119,533	4,146	Various	4,146		84,981	28
29	2007 Fixed Assets			2007	90,478	412	Various	412		90,478	29
30	2008 Fixed Assets			2008	47,724	3,304	Various	3,304		34,948	30
31	2010 Fixed Assets			2010	2,349		3			2,349	31
32	2011 Fixed Assets			2011	34,912	2,730	Various	2,730		25,429	32
33	2012 Fixed Assets			2012	151,427	6,262	Various	6,262		32,428	33
34	2013 Fixed Assets			2013	236,391	16,814	Various	16,814		76,971	34
35	Wander Guard			2015	12,000	800	20	800		1,933	35
36	Wander Guard			2015	11,880	1,188	10	1,188		2,772	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Roof	2015	$ 21,667	$ 1,083	20	$ 1,083	$	$ 2,528	37
38	Roof	2015	21,667	1,083	20	1,083		2,438	38
39	Roof	2015	21,667	1,083	20	1,083		2,438	39
40	Wander Guard	2015	4,605	460	10	460		1,036	40
41	Roof	2015	1,900	95	20	95		198	41
42	Wander Guard	2015	4,089	409	10	409		954	42
43	Condensing Unit	2016	4,489	449	10	449		823	43
44	Wander Guard	2016	7,791	779	10	779		1,298	44
45	Wander Guard	2016	4,089	409	10	409		784	45
46	FIN 47 Asset		20,377	1,692	12	1,692		18,638	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,940,229	$ 105,983		$ 105,983	$	$ 4,440,163	70

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 321,280	$ 31,026	$ 31,026	$	VAR	$ 186,863	71
72	Current Year Purchases	63,368	4,882	4,882		VAR	4,882	72
73	Fully Depreciated Assets	2,156,999				VAR	2,156,999	73
74								74
75	TOTALS	$ 2,541,647	$ 35,908	$ 35,908	$		$ 2,348,744	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1990 Van - 275	1990	$ 40,188	$	$	$	10	$ 40,188	76
77	Facility Business	2005 Ford 20 Passenger Bus	2004	54,530	3,635	3,635		15	47,980	77
78	Facility Business	WheelChair Accessible Van	2007	45,800	1,885	1,885		10	45,800	78
79	Facility Business	2017 Dodge Van	2017	40,082	4,008	4,008		10	4,008	79
80	TOTALS			$ 180,600	$ 9,528	$ 9,528	$		$ 137,976	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)	$ 8,828,771	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,419	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 151,419	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,926,883	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	Retirement Center/Assisted Living/	$	$	$	86
87	Apartments/Duplexes	27,277,163	730,856	11,046,240	87
88					88
89					89
90					90
91	TOTALS	$ 27,277,163	$ 730,856	$ 11,046,240	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	3,856	$ 188,696	$	3,856	$ 188,696	1
2	Licensed Speech and Language Development Therapist		hrs		1,388	53,454		1,388	53,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,241	321,962		4,241	321,962	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	9,485	$ 564,112	$	9,485	$ 564,112	14

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

STATE OF ILLINOIS

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 141,555	$	1
2	Cash-Patient Deposits	135		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 350,000)	936,360		3
4	Supply Inventory (priced at)	18,169		4
5	Short-Term Investments			5
6	Prepaid Insurance	45,493		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	5,462		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,147,174	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	292,890		13
14	Buildings, at Historical Cost	32,017,542		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,795,503		16
17	Accumulated Depreciation (book methods)	(17,973,123)		17
18	Deferred Charges	527,821		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): Debt Service Reserves	1,747,048		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 20,407,681	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,554,855	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 404,642	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	135		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	274,942		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	358,113		32
33	Accrued Interest Payable	94,457		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prelease Deposits/Ins. Proceeds	594,084		36
37	Other Accrued Expenses and LOC	1,175,713		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,902,086	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,000		39
40	Mortgage Payable			40
41	Bonds Payable	18,395,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	218,018		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 18,639,018	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 21,541,104	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ #NAME?	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ #NAME?	$	48

***(See instructions.)**

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 815,177	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 815,177	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	#NAME?	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)**	$ #NAME?	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)**	$ #NAME?	24 *

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

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	$ 8,985,755	1
2	Discounts and Allowances for all Levels	(2,195,140)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,790,615	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	7,510	5
6	Therapy	174,991	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 182,501	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	24,345	13
14	Non-Patient Meals	28,868	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	454	21
22	Laundry	5,960	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 59,627	23
	D. Non-Operating Revenue		
24	Contributions	97,897	24
25	Interest and Other Investment Income***	14,973	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112,870	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/Apt/Garden Home Revenue	4,380,609	28
28a	Other Revenue	89,502	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,470,111	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,615,724	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,684,251	31
32	Health Care	#NAME?	32
33	General Administration	2,793,441	33
	B. Capital Expense		
34	Ownership	1,659,114	34
	C. Ancillary Expense		
35	Special Cost Centers	172,576	35
36	Provider Participation Fee	246,188	36
	D. Other Expenses (specify):		
37	AL/IL/Retirement Center	766,608	37
38	Other Miscellaneous Expenses		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ #NAME?	40
41	**Income before Income Taxes (line 30 minus line 40)****	#NAME?	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ #NAME?	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,432,744	44
45	Private Pay - Net Inpatient Revenue	3,576,686	45
46	Medicare - Net Inpatient Revenue	1,376,748	46
47	Other-(specify) Managed Care	481,670	47
48	Other-(specify) Charity Care	(77,236)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,790,612	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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	3,811	4,228	$ 136,114	$ 32.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,736	9,365	257,472	27.49	3
4	Licensed Practical Nurses	31,312	33,914	799,771	23.58	4
5	CNAs & Orderlies	78,406	83,294	969,391	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,008	7,625	93,960	12.32	10
11	Social Service Workers	5,315	6,123	103,205	16.86	11
12	Dietician	35,910	39,251	421,057	10.73	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	10,709	11,574	151,168	13.06	17
18	Housekeepers	20,942	22,682	214,321	9.45	18
19	Laundry	9,409	10,190	96,289	9.45	19
20	Administrator	1,729	2,083	104,473	50.16	20
21	Assistant Administrator	1,862	2,109	86,241	40.89	21
22	Other Administrative	4,252	4,761	110,380	23.18	22
23	Office Manager					23
24	Clerical	6,518	7,279	109,392	15.03	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	2,509	3,143	41,568	13.23	31
32	Other Health Care(specify)	1,671	1,885	22,065	11.71	32
33	Other(specify)	53,730	60,542	728,089	12.03	33
34	TOTAL (lines 1 - 33)	283,829	310,048	$ 4,444,956 *	$ 14.34	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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	115	$ 6,691	10-3	50
51	Licensed Practical Nurses	1,066	37,868	10-3	51
52	Certified Nurse Assistants/Aides	8,770	188,215	10-3	52
53	TOTAL (lines 50 - 52)	9,951	$ 232,774		53

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Briehan	Adm - SNF	0	$ 52,236
(1/2 of salary is allocated to RCF)	Adm - RCF	0	52,236
Tina Kassing	Asst Admin	0	55,900
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,372

B. Administrative - Other

Description	Amount
Bad Debt	$ 670,767
Interest Expense	13,975
Bank Charges	3,608
Miscellaneous	7,510
TOTAL (agree to Schedule V, line 17, col. 3)	$ 695,860
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mathis Marifian & Richter, LTD	Legal	$ 17,666
Scheffel Boyle	Audit/Tax/Cost Report	30,350
Clerk of the Circuit Court		80
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 48,096

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,282
Unemployment Compensation Insurance	
FICA Taxes	331,667
Employee Health Insurance	483,284
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	46,081
General Incentives	38,370
Uniforms	1,651
RC Allocation	(221,551)
TOTAL (agree to Schedule V, line 22, col.8)	$ 841,784

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	1,910
Marketing, Advertising, and PR	47,535
Dues, Subscriptions, and Licenses	23,766
Less: Public Relations Expense	(256)
Non-allowable advertising	(47,279)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,676

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,620
Seminar Expense	3,850
Disallowed Travel and Seminar	(10,470)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. **AAHSA & LSN - $12,444**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

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

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

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

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

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **28,868**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees