FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

In the event there are further questions about this report, please contact:
Name: Steve Langendorf 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 1/1/2018 to 12/31/2018 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) Carrie Lewis
(Title) Director of Financial Services

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Steve Langendorf, 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: 1/1/2018 Ending: 12/31/2018

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	9,199	17,206	5,278	31,683	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,199	17,206	5,278	31,683	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.81%

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 3,165

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	426,264	75,642	18,277	520,183		520,183	(188,524)	331,659			1
2	Food Purchase		530,914		530,914		530,914	(252,165)	278,749			2
3	Housekeeping	220,887	69,450		290,337		290,337	(132,474)	157,863			3
4	Laundry	96,289	9,284		105,573		105,573	(40,074)	65,499			4
5	Heat and Other Utilities			541,356	541,356		541,356	(447,750)	93,606			5
6	Maintenance	216,224	2,810	383,709	602,743		602,743	(432,868)	169,875			6
7	Other (specify):*											7
8	TOTAL General Services	959,664	688,100	943,342	2,591,106		2,591,106	(1,493,855)	1,097,251			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	2,385,387	160,134	435,069	2,980,590		2,980,590	(121,377)	2,859,213			10
10a	Therapy		968	560,967	561,935		561,935		561,935			10a
11	Activities	520,877	5,933	5,398	532,208		532,208	(423,524)	108,684			11
12	Social Services	87,083	2,012	6,211	95,306		95,306		95,306			12
13	CNA Training											13
14	Program Transportation	22,551	3,392	4,091	30,034		30,034	(22,603)	7,431			14
15	Other (specify):* Seniors N Motion	25,582			25,582		25,582	(25,582)				15
16	TOTAL Health Care and Programs	3,041,480	172,439	1,044,736	4,258,655		4,258,655	(593,086)	3,665,569			16
	C. General Administration											
17	Administrative	175,103	705	148,111	323,919		323,919	(170,839)	153,080			17
18	Directors Fees											18
19	Professional Services			29,101	29,101		29,101		29,101			19
20	Dues, Fees, Subscriptions & Promotions			60,987	60,987		60,987	(33,986)	27,001			20
21	Clerical & General Office Expenses	284,776	45,145	169,091	499,012		499,012	(309,986)	189,026			21
22	Employee Benefits & Payroll Taxes			1,043,767	1,043,767		1,043,767	(248,089)	795,678			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,057	4,057		4,057	(4,057)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			294,001	294,001		294,001	(243,165)	50,836			26
27	Other (specify):* Supplies & Mtg/Development		2,713	5,328	8,041		8,041	(8,041)				27
28	TOTAL General Administration	459,879	48,563	1,754,443	2,262,885		2,262,885	(1,018,163)	1,244,722			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,461,023	909,102	3,742,521	9,112,646		9,112,646	(3,105,104)	6,007,542			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: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			146,457	146,457		146,457		146,457			30
31	Amortization of Pre-Op. & Org.			28,272	28,272		28,272		28,272			31
32	Interest			1,079,782	1,079,782		1,079,782	(1,116,906)	(37,124)			32
33	Real Estate Taxes			410,138	410,138		410,138	(410,138)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,664,649	1,664,649		1,664,649	(1,527,044)	137,605			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			152,342	152,342		152,342		152,342			39
40	Barber and Beauty Shops	51,944	1,473		53,417		53,417	(28,761)	24,656			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			237,163	237,163		237,163		237,163			42
43	Other (specify):* AL/Retirement Center			694,740	694,740		694,740	(694,740)				43
44	**TOTAL Special Cost Centers**	51,944	1,473	1,084,245	1,137,662		1,137,662	(723,501)	414,161			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,512,967	910,575	6,491,415	11,914,957		11,914,957	(5,355,649)	6,559,308			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: 1/1/2018 Ending: 12/31/2018

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	(25,582)	15		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(29,830)	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	(37,223)	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	(14,372)	17		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	(113,081)	17		24
25	Fund Raising, Advertising and Promotional	(33,986)	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)**	$ (254,074)		$	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))**	$ (254,074)		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

Summary A

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(188,524)	0	0	0	0	0	0	0	0	0	0	(188,524)	1
2	Food Purchase	(252,165)	0	0	0	0	0	0	0	0	0	0	(252,165)	2
3	Housekeeping	(132,474)	0	0	0	0	0	0	0	0	0	0	(132,474)	3
4	Laundry	(40,074)	0	0	0	0	0	0	0	0	0	0	(40,074)	4
5	Heat and Other Utilities	(447,750)	0	0	0	0	0	0	0	0	0	0	(447,750)	5
6	Maintenance	(432,868)	0	0	0	0	0	0	0	0	0	0	(432,868)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,493,855)	0	0	0	0	0	0	0	0	0	0	(1,493,855)	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	(121,377)	0	0	0	0	0	0	0	0	0	0	(121,377)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(423,524)	0	0	0	0	0	0	0	0	0	0	(423,524)	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	(22,603)	0	0	0	0	0	0	0	0	0	0	(22,603)	14
15	Other (specify):*	(25,582)	0	0	0	0	0	0	0	0	0	0	(25,582)	15
16	**TOTAL Health Care and Programs**	(593,086)	0	0	0	0	0	0	0	0	0	0	(593,086)	16
	C. General Administration													
17	Administrative	(170,839)	0	0	0	0	0	0	0	0	0	0	(170,839)	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	(33,986)	0	0	0	0	0	0	0	0	0	0	(33,986)	20
21	Clerical & General Office Expenses	(309,986)	0	0	0	0	0	0	0	0	0	0	(309,986)	21
22	Employee Benefits & Payroll Taxes	(248,089)	0	0	0	0	0	0	0	0	0	0	(248,089)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,057)	0	0	0	0	0	0	0	0	0	0	(4,057)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(243,165)	0	0	0	0	0	0	0	0	0	0	(243,165)	26
27	Other (specify):*	(8,041)	0	0	0	0	0	0	0	0	0	0	(8,041)	27
28	**TOTAL General Administration**	(1,018,163)	0	0	0	0	0	0	0	0	0	0	(1,018,163)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,105,104)	0	0	0	0	0	0	0	0	0	0	(3,105,104)	29

Eden Village Care Center

ID# 0023382

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RC-Dietary	$ (188,524)	1	1
2	RC-Food	(222,335)	2	2
3	RC-Housekeeping	(132,474)	3	3
4	RC-Laundry	(40,074)	4	4
5	RC-Heat & Utilities	(447,750)	5	5
6	RC-Maintenance	(402,395)	6	6
7	RC-Program Transportation	(16,025)	14	7
8	RC-Administrative	(43,386)	17	8
9	RC-Clerical & Office	(287,721)	21	9
10	RC-Employee Benefits/PR Taxes	(248,089)	22	10
11	RC-Insurance	(243,165)	26	11
12	RC-Direct Expenses (Depreciation)	(671,617)	43	12
13	RC-Activities Salaries	(423,524)	11	13
14	RC-Receptionist	(121,377)	10	14
15	Real Estate Taxes on RC	(410,138)	33	15
16	Marketing/Development Salaries	(8,041)	27	16
17	Lab, Xray, Ambulance services	(23,123)	43	17
18	RC-Interest Expeense on RC building	(1,079,683)	32	18
19	RC-Barber & Beauty	(28,761)	40	19
20	Other Revenue - Personal Purchases Misc.	(2,485)	21	20
21	Other Revenue - Transportation	(6,578)	14	21
22	Other Revenue - Senior TV	(30,473)	6	22
23	Other Revenue - Internet Purchases	(5,784)	21	23
24	Other Revenue - Phone Revenue CC Residents	(13,996)	21	24
25	Travel & Seminar	(4,057)	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**	(5,101,575)		49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

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	(1,116,906)	0	0	0	0	0	0	0	0	0	0	(1,116,906)	32
33	Real Estate Taxes	(410,138)	0	0	0	0	0	0	0	0	0	0	(410,138)	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**	(1,527,044)	0	0	0	0	0	0	0	0	0	0	(1,527,044)	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	(28,761)	0	0	0	0	0	0	0	0	0	0	(28,761)	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):*	(694,740)	0	0	0	0	0	0	0	0	0	0	(694,740)	43
44	**TOTAL Special Cost Centers**	(723,501)	0	0	0	0	0	0	0	0	0	0	(723,501)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(5,355,649)	0	0	0	0	0	0	0	0	0	0	(5,355,649)	45

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 2/31/2018

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: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Series 2006 Revenue Bonds		X	Construction & Equipment		12/1/2006	$ 22,390,000	$ 17,830,000	2/1/2036	5.00-5.85	$ 1,053,778	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	425,000			26,004	6
7												7
8												8
9	TOTAL Facility Related						$ 23,440,000	$ 18,255,000			$ 1,079,782	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	$ 18,255,000			$ 1,079,782	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	358,113	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.)	$	190,161	2
3. Under or (over) accrual (line 2 minus line 1).	$	(167,952)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	578,090	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.	$	410,138	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	322,719	8
	2014	327,229	9
	2015	338,490	10
	2016	345,200	11
	2017	380,322	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 Carrie Lewis

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 2017 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 2017.

	(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	$ 124.68	$
2.	14-1-15-26-02-202-098.001	NE/C NE	$ 71.20	$
3.	14-2-15-26-02-202-101	Cottonwood Trace - First Add LT PT	$ 1,559.40	$
4.	14-2-15-26-02-202-097	Cottonwood Trace PT Lot 2	$ 11,161.24	$
5.	14-2-15-26-02-202-165	Eden Village Subd 1st Addn Lot 1	$ 71,147.84	$
6.	14-2-15-26-02-202-100	Cottonwood Trace First Add PT Lots	$ 296,258.08	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 380,322.44	$

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? 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 12/31/2018

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		32,653	12
13	1991 Fixed Assets			1991	20,835		Various			20,835	13
14	1992 Fixed Assets			1992	106,730		Various			106,730	14
15	1993 Fixed Assets			1993	68,267	1,428	Various	1,428		68,267	15
16	1994 Fixed Assets			1994	42,035	750	Various	750		41,910	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		Various			6,000	19
20	1998 Fixed Assets			1998	1,632,945		Various			920,299	20
21	1999 Fixed Assets			1999	620,363	12,648	Various	12,648		362,396	21
22	2000 Fixed Assets			2000	31,137	24,907	Various	24,907		24,420	22
23	2001 Fixed Assets			2001	59,749		Various			59,749	23
24	2002 Fixed Assets			2002	9,200	368	Various	368		5,930	24
25	2003 Fixed Assets			2003	9,961	259	Various	259		8,065	25
26	2004 Fixed Assets			2004	23,265	959	Various	959		14,898	26
27	2005 Fixed Assets			2005	178,706	1,170	Various	1,170		165,545	27
28	2006 Fixed Assets			2006	119,533	4,146	Various	4,146		89,127	28
29	2007 Fixed Assets			2007	90,478		Various			90,478	29
30	2008 Fixed Assets			2008	47,724	3,304	Various	3,304		38,252	30
31	2010 Fixed Assets			2010	2,349		3			2,349	31
32	2011 Fixed Assets			2011	34,912	2,730	Various	2,730		28,159	32
33	2012 Fixed Assets			2012	151,427	6,262	Various	6,262		38,690	33
34	2013 Fixed Assets			2013	236,391	16,814	Various	16,814		93,785	34
35	Wander Guard			2015	12,000	800	20	800		2,733	35
36	Wander Guard			2015	11,880	1,188	10	1,188		3,960	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: 1/1/2018 Ending: 12/31/2018

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	$	$ 3,611	37
38	Roof	2015	21,667	1,083	20	1,083		3,521	38
39	Roof	2015	21,667	1,083	20	1,083		3,521	39
40	Wander Guard	2015	4,605	460	10	460		1,496	40
41	Roof	2015	1,900	95	20	95		293	41
42	Wander Guard	2015	4,089	409	10	409		1,363	42
43	Condensing Unit	2016	4,489	449	10	449		1,272	43
44	Wander Guard	2016	7,791	779	10	779		2,077	44
45	Wander Guard	2016	4,089	409	10	409		1,193	45
46	FIN 47 Asset		20,377	1,692	12	1,692		20,330	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	$ 86,427		$ 86,427	$	$ 4,541,333	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: 1/1/2018 Ending: 12/31/2018

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	$ 381,424	$ 35,908	$ 35,908	$		$ 221,429	71
72	Current Year Purchases	132,500	9,429	9,429			9,429	72
73	Fully Depreciated Assets	2,156,999					2,156,999	73
74								74
75	TOTALS	$ 2,670,923	$ 45,337	$ 45,337	$		$ 2,387,857	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 Van	2004	54,530	3,635	3,635		15	51,615	77
78	Facility Business	WheelChair Accessible Van	2007	45,800	1,885	1,885		10	47,685	78
79	Facility Business	2017 Dodge Van	2017	40,082	4,008	4,008		10	8,016	79
80	TOTALS			$ 180,600	$ 9,528	$ 9,528	$		$ 147,504	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)	$ 8,958,047	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 141,292	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 141,292	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)	$ 7,076,694	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	671,617	11,717,857	87
88					88
89					89
90					90
91	TOTALS	$ 27,277,163	$ 671,617	$ 11,717,857	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: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 12/31/2018

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	$	4,119	$ 205,817	$	4,119	$ 205,817	1
2	Licensed Speech and Language Development Therapist		hrs		1,619	62,400		1,619	62,400	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,494	292,754		4,494	292,754	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			$	10,232	$ 560,971	$	10,232	$ 560,971	14

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 209,447	$	1
2	Cash-Patient Deposits	884		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 151,434)	1,262,862		3
4	Supply Inventory (priced at)	11,344		4
5	Short-Term Investments			5
6	Prepaid Insurance	114,515		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	5,538		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,604,590	$	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	32,122,158		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,826,609		16
17	Accumulated Depreciation (book methods)	(18,794,551)		17
18	Deferred Charges	499,549		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	1,808,514		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 19,755,169	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,359,759	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 610,896	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	405		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	287,789		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,560		31
32	Accrued Real Estate Taxes(Sch.IX-B)	578,090		32
33	Accrued Interest Payable	94,606		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prelease Deposits/Ins. Proceeds	328,200		36
37	Other Accrued Expenses and LOC	1,136,227		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,039,773	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,000		39
40	Mortgage Payable			40
41	Bonds Payable	17,830,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	167,974		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 18,011,974	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 21,051,747	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 308,012	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,359,759	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,751	1
2	Restatements (describe):		2
3	2017 Audit Adjustment	(10,502)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,249	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	304,763	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)**	$ 304,763	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)**	$ 308,012	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,010,545	1
2	Discounts and Allowances for all Levels	(1,835,831)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,174,714	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	8,702	5
6	Therapy	206,088	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 214,790	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	24,965	13
14	Non-Patient Meals	29,830	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	2,489	21
22	Laundry	7,800	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 65,084	23
	D. Non-Operating Revenue		
24	Contributions	9,613	24
25	Interest and Other Investment Income***	29,896	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 39,509	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/Apt/Garden Home Revenue	4,654,163	28
28a	Other Revenue	71,460	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,725,623	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,219,720	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,591,106	31
32	Health Care	4,258,655	32
33	General Administration	2,262,885	33
	B. Capital Expense		
34	Ownership	1,664,649	34
	C. Ancillary Expense		
35	Special Cost Centers	205,759	35
36	Provider Participation Fee	237,163	36
	D. Other Expenses (specify):		
37	AL/IL/Retirement Center	694,740	37
38	Other Miscellaneous Expenses		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,914,957	40
41	**Income before Income Taxes (line 30 minus line 40)****	304,763	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 304,763	43

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

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,923	5,012	$ 170,669	$ 34.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,771	9,934	310,601	31.27	3
4	Licensed Practical Nurses	28,235	31,215	769,559	24.65	4
5	CNAs & Orderlies	69,291	70,130	949,182	13.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,189	5,693	97,353	17.10	10
11	Social Service Workers	4,998	5,598	90,740	16.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,795	35,985	426,264	11.85	15
16	Dishwashers					16
17	Maintenance Workers	11,287	11,838	165,419	13.97	17
18	Housekeepers	20,017	21,636	218,852	10.12	18
19	Laundry	8,993	9,721	98,325	10.11	19
20	Administrator	1,369	1,661	82,812	49.86	20
21	Assistant Administrator	2,753	3,051	74,855	24.53	21
22	Other Administrative	3,822	4,837	143,708	29.71	22
23	Office Manager					23
24	Clerical	6,473	7,152	116,949	16.35	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	3,868	4,306	54,118	12.57	31
32	Other Health Care(specify)	1,892	1,972	25,582	12.97	32
33	Other(specify)	54,612	58,393	717,979	12.30	33
34	TOTAL (lines 1 - 33)	270,288	288,134	$ 4,512,967 *	$ 15.66	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	925	$ 47,234	10-3	50
51	Licensed Practical Nurses	2,349	86,709	10-3	51
52	Certified Nurse Assistants/Aides	11,504	272,040	10-3	52
53	TOTAL (lines 50 - 52)	14,778	$ 405,983		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Schaller	Adm-SNF	0	$ 9,758
Sara McMahan	Adm-SNF	0	31,648
(1/2 of salary is allocated to RCF)	Adm-RCF	0	41,406
Tina Kassing	Asst Admin	0	59,983
Robin Sims		0	32,308
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 175,103

B. Administrative - Other

Description	Amount
Bad Debt	$ 113,081
Interest Expense	13,980
Bank Charges	3,626
Miscellaneous	17,424
TOTAL (agree to Schedule V, line 17, col. 3)	$ 148,111
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mathis Marifian & Richter, LTD	Legal	$ 2,891
Scheffel Boyle	Audit/Tax/Cost Report	26,210
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 29,101

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,565
Unemployment Compensation Insurance	18,723
FICA Taxes	337,305
Employee Health Insurance	486,211
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	34,053
General Incentives	34,985
Uniforms	925
RC Allocation	(248,089)
TOTAL (agree to Schedule V, line 22, col.8)	$ 795,678

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	1,600
Marketing, Advertising, and PR	35,434
Dues, Subscriptions, and Licenses	23,953
Less: Public Relations Expense	(487)
Non-allowable advertising	(33,499)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,001

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,451
Seminar Expense	2,606
Entertainment Expense	(4,057)
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **AAHSA & LSN - $16,346**

(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. $

(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