		FOR BHF USE				

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0005462

Facility Name: The Arthur Home

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

County: Moultrie

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

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1958

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: Lashelle Plank Telephone Number: 217-543-4551
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/19 to 08/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	CliftonLarsonAllen, LLP 600 Washington Ave, Suite 1800, St. Louis, MO 63101
	(Telephone)	314-925-4441 Fax # 314-925-4350

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

STATE OF ILLINOIS

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	53	Skilled (SNF)	53	19,398	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	53	TOTALS	53	19,398	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,021	6,748	4,378	19,147	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,021	6,748	4,378	19,147	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.71%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 53 and days of care provided 1,754

Medicare Intermediary Wisconsin Physician Services, Inc. (WPS)

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 8/31/2020 Fiscal Year: 8/31/2020

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

Facility Name & ID Number: The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	218,934	9,419	10,161	238,514		238,514		238,514			1
2	Food Purchase		121,264		121,264		121,264	(1,120)	120,144			2
3	Housekeeping	134,946	15,885	235	151,066		151,066		151,066			3
4	Laundry	66,602	11,738		78,340		78,340		78,340			4
5	Heat and Other Utilities			52,111	52,111		52,111		52,111			5
6	Maintenance	75,584	14,082	88,476	178,142		178,142	(11,438)	166,704			6
7	Other (specify):*											7
8	**TOTAL General Services**	496,066	172,388	150,983	819,437		819,437	(12,558)	806,879			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,524,453	84,310	51,926	1,660,689		1,660,689		1,660,689			10
10a	Therapy											10a
11	Activities	62,263	3,603	5,371	71,237	(1,929)	69,308	(1,942)	67,366			11
12	Social Services	44,279	221		44,500	1,929	46,429		46,429			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,630,995	88,134	73,797	1,792,926		1,792,926	(1,942)	1,790,984			16
	C. General Administration											
17	Administrative	90,850			90,850		90,850		90,850			17
18	Directors Fees											18
19	Professional Services			72,556	72,556		72,556		72,556			19
20	Dues, Fees, Subscriptions & Promotions			10,717	10,717		10,717	(193)	10,524			20
21	Clerical & General Office Expenses	175,874	8,103	196,191	380,168		380,168	(360,356)	19,812			21
22	Employee Benefits & Payroll Taxes			325,427	325,427		325,427		325,427			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,313	3,313		3,313		3,313			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,013	68,013		68,013		68,013			26
27	Other (specify):*											27
28	**TOTAL General Administration**	266,724	8,103	676,217	951,044		951,044	(360,549)	590,495			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,393,785	268,625	900,997	3,563,407		3,563,407	(375,049)	3,188,358			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.

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			76,280	76,280		76,280	(2,633)	73,647			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			121,370	121,370		121,370		121,370			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			20,672	20,672		20,672	(20,672)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			218,322	218,322		218,322	(23,305)	195,017			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			315,754	315,754		315,754		315,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,347	123,347		123,347		123,347			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			439,101	439,101		439,101		439,101			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,393,785	268,625	1,558,420	4,220,830		4,220,830	(398,354)	3,822,476			45

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,120)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,583)	21		24
25	Fund Raising, Advertising and Promotional	(193)	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	(358,447)	PG5A		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (398,354)		$	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))**	$ (398,354)		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

The Arthur Home

ID# 0005462

Report Period Beginning: 09/01/19

Ending: 08/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3	Second Wind Dreams	(415)	21	3
4	Intercompany Space Rental	(20,672)	34	4
5				5
6	Activity Contributions	(1,942)	11	6
7	Transportation Income	(11,438)	6	7
8	Misc. Income	(299,839)	21	8
9	Farm Land Rent	(17,695)	21	9
10				10
11	Property Taxes	(3,813)	21	11
12				12
13	Depreciation Adjustment	(2,633)	30	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(358,447)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,120)	0	0	0	0	0	0	0	0	0	0	(1,120)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(11,438)	0	0	0	0	0	0	0	0	0	0	(11,438)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,558)	0	0	0	0	0	0	0	0	0	0	(12,558)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,942)	0	0	0	0	0	0	0	0	0	0	(1,942)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,942)	0	0	0	0	0	0	0	0	0	0	(1,942)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(193)	0	0	0	0	0	0	0	0	0	0	(193)	20
21	Clerical & General Office Expenses	(360,356)	0	0	0	0	0	0	0	0	0	0	(360,356)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(360,549)	0	0	0	0	0	0	0	0	0	0	(360,549)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(375,049)	0	0	0	0	0	0	0	0	0	0	(375,049)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(2,633)	0	0	0	0	0	0	0	0	0	0	(2,633)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(20,672)	0	0	0	0	0	0	0	0	0	0	(20,672)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,305)	0	0	0	0	0	0	0	0	0	0	(23,305)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(398,354)	0	0	0	0	0	0	0	0	0	0	(398,354)	45

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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 The Arthur Home # 0005462 **Report Period Beginning:** 09/01/19 **Ending:** 08/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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]

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	First Mid-Illinois Bank		x	Real Estate Finance	$8,202.50	1/5/15	$ 1,325,000	$ 1,057,271	3/1/26	4.2500	$ 49,581	1
2	First Mid-Illinois Bank		x	Operating Loan	$3,073.76	3/1/16	300,000	176,288	3/1/26	4.2500	10,441	2
3	First Mid-Illinois Bank		x	Room/Hallway renovation	semi-annual	6/1/18	350,000	331,600	5/15/21	5.2500	1,447	3
4	First Mid-Illinois Bank		x	Eberhardt IL Construction	None	3/29/17	400,000	152,456	3/29/18	4.7500	17,232	4
5	ONR Note		x	Working Capital	None	8/25/16	72,539		8/25/17	4.0000	1,053	5
	Working Capital											
6	Private Loans		x	Working Capital	None	6/13/12	174,019	186,103	6/13/13	4.0000	6,083	6
7	Greencroft LOC		x	Working Capital	None	10/26/12	200,000	200,000	None	6.2500	27,366	7
8	SHF Note/Promissory Note/Othe	x		Working Capital	None	8/25/16	120,000	120,076	None	various	8,167	8
9	TOTAL Facility Related				$11,276.26		$ 2,941,558	$ 2,223,794			$ 121,370	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,941,558	$ 2,223,794			$ 121,370	15

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arthur Home COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT Lashelle Plank

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

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	Facility pays realestate taxes on		$	$
2.	non-care assets. All costs are		$	$
3.	adjusted out of report		$	$
4.	03-03-25-406-017	PT SW 1/4 SE 1/4	$ 326.00	$
5.	03-03-25-406-020	431 W Palmer Road	$ 49,911.54	$
6.	03-03-25-406-021	PT SW 1/4 SE 1/4	$ 7,497.22	$
7.	03-03-25-425-010	N PT SW 1/4 SE 1/4 Gibson	$ 612.38	$
8.	03-03-25-425-011	N PT SW 1/4 SE 1/4 Gibson Add	$ 101.60	$
9.			$	$
10.			$	$
		TOTALS	$ 58,448.74	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

Eberhardt Village, Inc. - assisted living facility - 40,000 square feet - 36 beds
Independent Living, LLC - Indepdent Living apartments

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	152,469	1959	$ 264,084	1
2					2
3	TOTALS	152,469		$ 264,084	3

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	25		1959	1959	$ 124,966	$	33	$	$	$ 124,966	4
5	28		1975	1975	308,252		33			308,252	5
6											6
7											7
8											8
	Improvement Type**										
9	1987 Fixed Assets			1987	99,897		Various			99,897	9
10	1989 Fixed Assets			1989	4,907		Various			4,907	10
11	1990 Fixed Assets			1990	43,501		Various			43,501	11
12	1992 Fixed Assets			1992	39,028		Various			39,028	12
13	1993 Fixed Assets			1993	10,165		Various			10,165	13
14	1994 Fixed Assets			1994	12,664		Various			12,664	14
15	1995 Fixed Assets			1995	42,675		Various			42,675	15
16	1996 Fixed Assets			1996	4,283		Various			4,283	16
17	1997 Fixed Assets			1997	48,637		Various			48,637	17
18	1998 Fixed Assets			1998	21,991		Various			21,991	18
19	1999 Fixed Assets			1999	1,817	64	Various	64		1,610	19
20	2000 Fixed Assets			2000	2,289	8	Various	8		2,289	20
21	2001 Fixed Assets			2001	8,851	339	Various	339		8,595	21
22	2002 Fixed Assets			2002	28,509	1,425	Various	1,425		25,812	22
23	2004 Fixed Assets			2004	11,827		Various			11,827	23
24	2005 Fixed Assets			2005	67,345	2,536	Various	2,536		57,231	24
25	2006 Fixed Assets			2006	5,518	37	Various	37		5,304	25
26	2007 Fixed Assets			2007	17,576	530	Various	530		14,141	26
27	2008 Fixed Assets			2008	6,477,894	30,896	Various	30,896		5,648,678	27
28	2009 Fixed Assets			2009	28,837	1,395	Various	1,395		19,584	28
29	2010 Fixed Assets			2010	10,638	272	Various	272		10,638	29
30	2011 Fixed Assets			2011	9,460	854	Various	854		8,059	30
31	2012 Fixed Assets			2012	30,883	2,263	Various	2,263		27,627	31
32	2013 Fixed Assets			2013	12,623		Various			12,623	32
33	2014 Fixed Assets			2014	5,119	386	Various	386		2,326	33
34	2015 Fixed Assets			2015	1,861	186	Various	186		1,090	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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			$	$		$	$	$	37
38	Part S Tube Lakeview	2016	935		2			935	38
39	Replace Part of Main Sewer Drain	2016	1,520	152	10	152		760	39
40	Activity Room Flooring	2017	3,680	184	20	184		629	40
41	Activity Room Floor	2017	766	77	10	77		262	41
42	Intercom	2017	1,276	347	4	347		1,245	42
43	File Cabinets for Medical Records	2018	1,754	585	3	585		1,177	43
44	Boiler	2019	508	141	3	141		282	44
45									45
46	Room Renovation (1 entry in PPE Fixed Asset Ledger)								46
47	Hall 20 - 8 resident rooms & hallway (3,169 sq ft)								47
48	Hall 30 - 8 resident rooms, family lounge, Med Rm & hallway (3,642 sq ft)								48
49	Hall 40 - 7 resident rooms, 2 offices and hallway (3,008 sq ft)								49
50	Flooring - Vinyl Tile, Pressure sensative glue	2019	67,649	6,765	10	6,765		8,456	50
51	Railing - wood railing down both sides of all hallwyas	2019	5,744	574	10	574		718	51
52	Cabinets - for family lounge & conference room	2019	662	66	10	66		82	52
53	Fixtures - bathroom faucits	2019	4,538	454	10	454		568	53
54	Plumbing - Bathroom replace pipes	2019	7,276	728	10	728		910	54
55	Blinds - Faux wood blind, ISM and valance	2019	4,663	466	10	466		582	55
56	Faucit - lumber & sheet rock to construct faucit to cover pipes	2019	4,041	404	10	404		505	56
57	Trim & baseboards	2019	5,290	529	10	529		661	57
58	Painting	2019	4,661	466	10	466		582	58
59	Inhouse Labor	2019	6,387	639	10	639		799	59
60	Furniture - Electric Beds, Mattress, 3 drawer beside cabinet	2019	33,340	3,334	10	3,334		4,168	60
61	4 drawer dresser, vinyl recliner lift chair, table/4 chairs								61
62	office chairs, flat screen TV								62
63									63
64	Boiler	2019	907	49	10	49		49	64
65	Boiler	2019	2,020	314	10	314		314	65
66	Sprinkler System	2020	33,387	3,339	10	3,339		3,339	66
67	Metal Roof	2020	44,700	373	10	373		373	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,717,717	$ 61,176		$ 61,176	$	$ 6,645,796	70

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

Facility Name & ID Number: The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	$ 242,969	$ 12,098	$ 12,098	$	Various	$ 509,468	71
72	Current Year Purchases	2,064	373	373		Various	373	72
73	Fully Depreciated Assets	370,257						73
74								74
75	TOTALS	$ 615,290	$ 12,471	$ 12,471	$		$ 509,841	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Resident Bus	2019	$ 64,697	$	$	$	4	$ 13,479	76
77	Resident Care	2018 Dodge Van	2020	25,500				4		77
78	Resident Care	2004 Toyota Sienna & Van	2010	7,650				4	7,650	78
79	Resident Care	2004 Lincoln	2016	5,000				4	3,749	79
80	TOTALS			$ 102,847	$	$	$		$ 24,878	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)	$ 8,699,938	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 73,647	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 73,647	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)	$ 7,180,515	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 4,087	92
93			93
94			94
95		$ 4,087	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-2	0 hrs	$ 0	1,960	$ 115,492	$	1,960	$ 115,492	1
2	Licensed Speech and Language Development Therapist	39-2	0 hrs	0	1,383	91,726		1,383	91,726	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	0 hrs	0	888	57,948		888	57,948	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			41,426			41,426	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab/X-ray	39-2				12,001			12,001	12
13	Other (specify): Oxygen	39-2					8,932		8,932	13
14	TOTAL			$	4,231	$ 318,593	$ 8,932	4,231	$ 327,525	14

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

Facility Name & ID Number **The Arthur Home** # **0005462** Report Period Beginning: **09/01/19** Ending: **08/31/20**

XV. BALANCE SHEET - Unrestricted Operating Fund. As of **08/31/20** (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	$ 526,578	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	374,160		3
4	Supply Inventory (priced at)	14,345		4
5	Short-Term Investments			5
6	Prepaid Insurance	284,951		6
7	Other Prepaid Expenses	10,618		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Contribution Receivable	266,153		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,476,805	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	264,084		13
14	Buildings, at Historical Cost	7,409,519		14
15	Leasehold Improvements, at Historical Cost	309,440		15
16	Equipment, at Historical Cost	718,137		16
17	Accumulated Depreciation (book methods)	(7,180,515)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **See schedule**	3,755,051		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,275,716	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,752,521	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 338,635	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,225		28
29	Short-Term Notes Payable	651,940		29
30	Accrued Salaries Payable	197,769		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	29,160		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Payables	97,924		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,323,653	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,741,327		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Asset Retirement Obligation	103,671		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,844,998	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,168,651	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,583,870	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,752,521	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,655,439	1
2	Restatements (describe):		2
3	2019 Financial Statement Audit Adjustments	(284,573)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,370,866	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	213,004	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)**	$ 213,004	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)**	$ 3,583,870	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.

	1		
	I. Revenue	**Amount**	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,031,372	1
2	Discounts and Allowances for all Levels	(490,854)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,540,518	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	333,596	6
7	Oxygen	10,427	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 344,023	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,120	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	156,000	16
17	Sale of Drugs	46,611	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,546	19
20	Radiology and X-Ray	2,003	20
21	Other Medical Services	1,988	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 214,268	23
	D. Non-Operating Revenue		
24	Contributions	3,810	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,810	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule	331,215	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 331,215	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,433,834	30

	2		
	II. Expenses	**Amount**	
	A. Operating Expenses		
31	General Services	819,437	31
32	Health Care	1,792,926	32
33	General Administration	951,044	33
	B. Capital Expense		
34	Ownership	218,322	34
	C. Ancillary Expense		
35	Special Cost Centers	439,101	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,220,830	40
41	**Income before Income Taxes (line 30 minus line 40)****	213,004	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 213,004	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,179,812	44
45	Private Pay - Net Inpatient Revenue	1,871,408	45
46	Medicare - Net Inpatient Revenue	489,298	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,540,518	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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,462	1,599	$ 62,386	$ 39.02	1
2	Assistant Director of Nursing	245	273	8,176	29.95	2
3	Registered Nurses	4,123	4,516	137,447	30.44	3
4	Licensed Practical Nurses	15,458	16,373	403,068	24.62	4
5	CNAs & Orderlies	51,658	55,446	836,971	15.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,094	1,132	19,068	16.84	8
9	Activity Director	1,784	1,979	35,451	17.91	9
10	Activity Assistants	1,700	1,786	26,812	15.01	10
11	Social Service Workers	2,153	2,381	44,279	18.60	11
12	Dietician					12
13	Food Service Supervisor	2,259	2,408	38,734	16.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,841	17,633	180,200	10.22	15
16	Dishwashers					16
17	Maintenance Workers	3,724	4,087	75,584	18.49	17
18	Housekeepers	12,209	12,884	134,946	10.47	18
19	Laundry	5,087	5,627	66,602	11.84	19
20	Administrator	2,080	2,080	90,850	43.68	20
21	Assistant Administrator					21
22	Other Administrative	7,014	8,137	175,874	21.61	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS	1,770	2,002	57,337	28.64	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,661	140,343	$ 2,393,785 *	$ 17.06	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,382	1-3	35
36	Medical Director	Monthly	16,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,536	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,929	11-3	44
45	Social Service Consultant	Monthly	1,928	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,275		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		49,390		52
53	TOTAL (lines 50 - 52)		$ 49,390		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Sthepenson	Administrator	0	$ 90,850
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,850

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal Services	$ 40,574
CLA, LLP	Audit, Cost Reports & Taxes	30,277
Samueals, Miller, Schroder, Jackson	Disaster Plan Prepareness	1,704
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 72,556

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,499
Unemployment Compensation Insurance	1,867
FICA Taxes	188,353
Employee Health Insurance	39,007
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	346
Pension Contribution	29,355
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,427

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	$ 2,330
Advertising: Employee Recruitment	421
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues	5,977
Subscriptions	1,796
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,524

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	525
Seminar Expense	2,788
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,313

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Leading Age IL, $665**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,662** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **123,347**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **3,177**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.