

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 Arthur 61911
Number City Zip Code

County: Moultrie

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

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1958

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ 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: David Eversole Telephone Number: 217-543-2103
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2010 to 8/31/2011 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)
(Type or Print Name) David Eversole
(Title) Administrator

Paid
Preparer

(Signed)
(Print Name and Title) Chad D. Kunze, CPA
Principal
(Firm Name & Address) LarsonAllen LLP
600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4321 Fax # 314-925-4350

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

Facility Name & ID Number The Arthur Home

0005462 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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	<u>61</u>	Skilled (SNF)	<u>61</u>	<u>22,265</u>	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	<u>61</u>	TOTALS	<u>61</u>	<u>22,265</u>	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	<u>7,224</u>	<u>10,291</u>	<u>2,496</u>	<u>20,011</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,224</u>	<u>10,291</u>	<u>2,496</u>	<u>20,011</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.88%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 61 and days of care provided 2,260

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 8/31/2010 Fiscal Year: 8/31/2010

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	239,232	8,983	9,804	258,019		258,019	(51)	257,968			1
2	Food Purchase		145,860		145,860		145,860	(5,089)	140,771			2
3	Housekeeping	88,119	12,350	200	100,669		100,669		100,669			3
4	Laundry	71,831	10,059		81,890		81,890		81,890			4
5	Heat and Other Utilities			54,117	54,117		54,117		54,117			5
6	Maintenance	43,172	21,659	45,953	110,784		110,784		110,784			6
7	Other (specify):*											7
8	TOTAL General Services	442,354	198,911	110,074	751,339		751,339	(5,140)	746,199			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,099,134	95,586	194,283	1,389,003		1,389,003	(17,155)	1,371,848			10
10a	Therapy			307,770	307,770		307,770		307,770			10a
11	Activities	57,751	3,292	4,951	65,994		65,994	(163)	65,831			11
12	Social Services	26,864			26,864		26,864		26,864			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,183,749	98,878	511,804	1,794,431		1,794,431	(17,318)	1,777,113			16
	C. General Administration											
17	Administrative	37,953			37,953		37,953		37,953			17
18	Directors Fees											18
19	Professional Services			66,391	66,391		66,391		66,391			19
20	Dues, Fees, Subscriptions & Promotions			13,051	13,051		13,051	(4,642)	8,409			20
21	Clerical & General Office Expenses	132,869	32,439	84,183	249,491	(18,749)	230,742	(13,183)	217,559			21
22	Employee Benefits & Payroll Taxes			343,534	343,534		343,534		343,534			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,509	11,509		11,509		11,509			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			34,743	34,743		34,743		34,743			26
27	Other (specify):*											27
28	TOTAL General Administration	170,822	32,439	553,411	756,672	(18,749)	737,923	(17,825)	720,098			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,796,925	330,228	1,175,289	3,302,442	(18,749)	3,283,693	(40,283)	3,243,410			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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			78,650	78,650		78,650		78,650			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,474	8,474		8,474	(8,474)				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			107,796	107,796		107,796	(8,474)	99,322			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,047		117,047		117,047	(11,994)	105,053			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,458	33,458	18,749	52,207		52,207			42
43	Other (specify):* See Attachment			1,220,025	1,220,025		1,220,025	(1,220,025)				43
44	TOTAL Special Cost Centers		117,047	1,253,483	1,370,530	18,749	1,389,279	(1,232,019)	157,260			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,796,925	447,275	2,536,568	4,780,768		4,780,768	(1,280,776)	3,499,992			45

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

VI. ADJUSTMENT DETAIL

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

	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	(5,089)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,031)	43		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	(577)	43		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	(1,031)	43		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	(45,908)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,221,140)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,280,776)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,280,776)		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

The Arthur Home

ID#	0005462
Report Period Beginning:	9/1/2010
Ending:	8/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	X-Ray - Medicare Expense	\$ (6,663)	39	1
2	Lab - Medicare Expense	(5,331)	39	2
3	Eberhardt Village, Inc. (Assisted Living) Expenses	(1,165,478)	43	3
4	Interest Expense	(8,474)	32	4
5	Grant Revenue	(10,359)	21	5
6	Other Income	(2,824)	21	6
7	Activity Income	(163)	11	7
8	Transportation Income	(17,155)	10	8
9	Advertising Expense	(4,642)	20	9
10	Dietary Income	(51)	1	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,221,140)		49

Summary B

8/31/2011

[illegible]

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

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 3/31/2011

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

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							\$		\$			\$	1						
2													2						
3													3						
4													4						
5													5						
	Working Capital																		
6	State Bank of Arthur		X	Working Capital	None	8/30/2006	300,000	173,797	3/31/2012	4.0000	8,474	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 300,000	\$ 173,797			\$ 8,474	9							
	B. Non-Facility Related*																		
10	USDA		X	Construction	\$24,886.00	3/2/2007	5,721,000	5,706,000	3/1/2047	4.1250	235,991	10							
11	State Bank of Arthur		X	Construction	\$3,845.00	8/27/2008	375,000	346,954	8/27/2023	5.0000	18,104	11							
12	State Bank of Arthur		X	Working Capital	None	5/17/2008	590,000	578,764	3/31/2012	4.0000	26,492	12							
13												13							
14	TOTAL Non-Facility Related				\$28,731.00		\$ 6,686,000	\$ 6,631,718			\$ 280,587	14							
15	TOTALS (line 9+line14)						\$ 6,986,000	\$ 6,805,515			\$ 289,061	15							

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2011 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:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		12		

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

FACILITY NAME	<u>The Arthur Home</u>	COUNTY	<u>Moultrie</u>
FACILITY IDPH LICENSE NUMBER	<u>0005462</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>David Eversole</u>		
TELEPHONE	<u>217-543-2103</u>	FAX #:	<u>217-543-2278</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Eberhardt Village, Inc. - assisted living facility - 40,000 square feet - 36 beds

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ 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	\$ 2,085	1
2					2
3	TOTALS	152,469		\$ 2,085	3

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2010

Ending:

8/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Energy Recovery Ventilator	2008	\$ 1,096	\$ 110	10	\$ 110	\$	\$ 402	37
38 Data Addition	2008	2,737	274	10	274		980	38
39 Exterior Light Fixtures	2008	551	55	10	55		197	39
40 Fire Alarm System	2008	1,360	136	10	136		476	40
41 Data Addition	2008	8,137	814	10	814		2,780	41
42 Boiler	2008	612	31	20	31		97	42
43 Chair Rail	2008	528	53	10	53		167	43
44 Air Conditioner	2008	2,726	273	10	273		841	44
45 Code Alert Alarm	2008	790	79	10	79		243	45
46 Floor Tile	2008	504	50	10	50		147	46
47 Smoke Shack Floor	2008	625	31	20	31		88	47
48 Door Between AH & Offices	2008	625	31	20	31		86	48
49 Activated Light	2008	561	56	10	56		150	49
50 Sprinkler Heads	2009	992	99	10	99		265	50
51 Windows (14) Parkview	2009	6,628	442	15	442		1,178	51
52 Plumbing	2009	945	95	10	95		252	52
53 Basement Wall	2009	5,604	280	20	280		724	53
54 Room Remodel	2009	4,923	246	20	246		615	54
55 Sprinkler Heads	2009	1,127	56	20	56		141	55
56 Concrete-Patio	2009	797	40	20	40		93	56
57 Steps-Patio	2009	599	30	20	30		70	57
58 Lights-Hall 20	2009	1,054	70	15	70		164	58
59 Front Porch	2009	1,172	59	20	59		132	59
60 Bathroom Remodeling	2009	1,053	53	20	53		119	60
61 Carpet	2009	504	50	10	50		105	61
62 Front Sidewalk	2009	1,125	56	20	56		117	62
63 Fence	2009	4,231	423	10	423		1,320	63
64 Asbestos Inspection	2009	596	199	3	199		308	64
65 Lumber	2009	529	53	10	53		101	65
66 Wallpaper	2010	2,000	200	10	200		533	66
67 Front Sidewalk	2010	628	63	10	63		78	67
68 Wallpaper	2010	2,654	265	10	265		310	68
69 Wallpaper	2010	2,043	102	10	102		102	69
70 TOTAL (lines 4 thru 69)		\$ 970,152	\$ 24,604		\$ 24,604	\$	\$ 804,515	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:

9/1/2010

Ending:

8/31/2011

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	
1	Totals from Page 12A, Carried Forward		\$ 970,152	\$ 24,604		\$ 24,604	\$	\$ 804,515	1
2	Walpaper	2011	1,400	70	10	70		70	2
3	Windows	2011	2,760	92	15	92		92	3
4	Back Door	2011	3,257	109	10	109		109	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 977,569	\$ 24,875		\$ 24,875	\$	\$ 804,786	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$319,323	\$47,408	\$47,408	\$	Various	\$198,274	71
72	Current Year Purchases	55,201	3,017	3,017		Various	3,017	72
73	Fully Depreciated Assets	34,880				Various	34,880	73
74								74
75	TOTALS	\$409,404	\$50,425	\$50,425	\$		\$236,171	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1991 Aerostar Van	1986	\$15,110	\$	\$	\$	4	\$15,110	76
77	Resident Care	Handicap Bus	1991	45,103				4	45,103	77
78	Resident Care	Van & Conversion	2001	13,400	3,350	3,350		4	4,706	78
79										79
80	TOTALS			\$73,613	\$3,350	\$3,350	\$		\$64,919	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,462,671	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$78,650	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$78,650	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,105,876	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted Living Land	\$214,000	\$	\$	86
87	Assisted Living Building	6,425,273	160,417	495,281	87
88	Assisted Living Grounds	18,639	1,942	5,351	88
89	Assisted Living Vehicles	13,400	3,350	4,706	89
90	Assisted Living Equipment	296,603	20,782	60,227	90
91	TOTALS	\$6,967,915	\$186,491	\$565,565	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.

		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:
- *

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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ NO

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

See Attachment

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)	\$			

(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.

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	

(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		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	10A-3	hrs	\$	1,600	\$ 102,741	\$	1,600	\$ 102,741	1
2	Licensed Speech and Language Development Therapist		hrs		1,176	91,242		1,176	91,242	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,757	113,787		1,757	113,787	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			\$	4,533	\$ 307,770	\$	4,533	\$ 307,770	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 165,312	\$ 279,550	1
2	Cash-Patient Deposits	12,398	33,654	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,500)	480,876	483,399	3
4	Supply Inventory (priced at)	9,050	10,236	4
5	Short-Term Investments			5
6	Prepaid Insurance	9,898	3,765	6
7	Other Prepaid Expenses	1,277	3,154	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Trust Receivable	315,198	315,198	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 994,009	\$ 1,128,956	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,067	274,067	13
14	Buildings, at Historical Cost	669,317	7,094,590	14
15	Leasehold Improvements, at Historical Cost	308,252	326,891	15
16	Equipment, at Historical Cost	483,017	793,020	16
17	Accumulated Depreciation (book methods)	(1,105,876)	(1,671,441)	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 Due From Related Ent	1,315,165		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,729,942	\$ 6,817,127	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,723,951	\$ 7,946,083	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 232,822	\$ 245,988	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,398	34,054	28
29	Short-Term Notes Payable	173,797	752,561	29
30	Accrued Salaries Payable	111,352	130,951	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		81,217	32
33	Accrued Interest Payable	1,581	825,193	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	56,874	64,259	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 588,824	\$ 2,134,223	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		346,954	39
40	Mortgage Payable		5,706,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,052,954	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 588,824	\$ 8,187,177	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,135,127	\$ (231,196)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,723,951	\$ 7,955,981	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 135,866	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 135,866	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(367,062)	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)	\$ (367,062)	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)	\$ (231,196)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,243,051	1
2	Discounts and Allowances for all Levels	28,194	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,271,245	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	344,998	6
7	Oxygen	33,276	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 378,274	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	5,089	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	112,807	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,058	19
20	Radiology and X-Ray	8,125	20
21	Other Medical Services	9,247	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 140,326	23
	D. Non-Operating Revenue		
24	Contributions	25,544	24
25	Interest and Other Investment Income***	13,309	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,853	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Assisted Living Revenues	554,281	28
28a	See Attached Schedule	30,727	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 585,008	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,413,706	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	751,339	31
32	Health Care	1,794,431	32
33	General Administration	756,672	33
	B. Capital Expense		
34	Ownership	107,796	34
	C. Ancillary Expense		
35	Special Cost Centers	117,047	35
36	Provider Participation Fee	33,458	36
	D. Other Expenses (specify):		
37	Non-Allowable AL & Other Expenses	1,220,025	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,780,768	40
41	Income before Income Taxes (line 30 minus line 40)**	(367,062)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (367,062)	43

* 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.

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	1,794	1,990	\$ 59,712	\$ 30.01	1
2	Assistant Director of Nursing	1,763	1,815	42,657	23.50	2
3	Registered Nurses	4,079	4,434	91,607	20.66	3
4	Licensed Practical Nurses	14,984	16,257	319,117	19.63	4
5	CNAs & Orderlies	43,031	46,029	542,226	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,320	3,919	43,815	11.18	8
9	Activity Director	1,632	1,905	22,321	11.72	9
10	Activity Assistants	3,553	3,945	35,430	8.98	10
11	Social Service Workers	1,964	2,153	26,864	12.48	11
12	Dietician					12
13	Food Service Supervisor	1,029	1,166	17,740	15.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,433	23,826	221,492	9.30	15
16	Dishwashers					16
17	Maintenance Workers	2,557	2,758	43,172	15.65	17
18	Housekeepers	7,355	8,230	88,120	10.71	18
19	Laundry	6,591	7,131	71,830	10.07	19
20	Administrator	839	1,012	37,953	37.50	20
21	Assistant Administrator					21
22	Other Administrative	4,793	5,449	94,086	17.27	22
23	Office Manager	1,818	2,031	38,783	19.10	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 Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,535	134,050	\$ 1,796,925 *	\$ 13.40	34

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	85	\$ 4,851	1-3	35
36	Medical Director	Monthly	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	1,817	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,822	11-3	44
45	Social Service Consultant	24	1,822	11-3	45
46	Other(specify) Dental	12	1,320	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	205	\$ 16,432		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	541	\$ 27,424	10-3	50
51	Licensed Practical Nurses	1,173	46,223	10-3	51
52	Certified Nurse Assistants/Aides	4,998	114,439	10-3	52
53	TOTAL (lines 50 - 52)	6,712	\$ 188,086		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
David Eversole	Administrator		\$ 37,953
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 37,953
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
LarsonAllen LLP	Accounting		\$ 22,103
Samuels, Miller, Jackson, Schroeder,	Legal		1,768
Polisnelli	Legal		6,895
Greencroft Communities	Management Fees		35,625
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 66,391
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 59,960
Unemployment Compensation Insurance			18,499
FICA Taxes			135,607
Employee Health Insurance			117,284
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			1,508
Pension Contributions			10,676
TOTAL (agree to Schedule V, line 22, col.8)			\$ 343,534
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			5,742
Health Care Worker Background Check (Indicate # of checks performed)	20		560
Patient Background Checks	55		550
Fundraising and Volunteering			557
Vehicle License			99
Dues			3,894
Other Licenses			1,137
Other Taxes			512
Less: Public Relations Expense		(	)
Non-allowable advertising			(4,642)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 8,409
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$ 2,066
In-State Travel			4,488
Seminar Expense			4,955
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 11,509

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$2,418; AAHSA - \$1,443
- (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? _____
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,196 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. _____
- (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. \$ 52,207
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. \$ 5,089
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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? _____
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: LarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.