

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: Linda Butler 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 9/1/2011 to 8/31/2012 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) Gale Pearce
(Title) Board President

Paid
Preparer

(Signed)
(Print Name and Title) Allan B. Larson
Partner
(Firm Name & Address) CliftonLarsonAllen 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: 9/1/2011 Ending: 8/31/2012

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 7/17/12

	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>53</u>	<u>21,950</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>53</u>	<u>21,950</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,782</u>	<u>9,914</u>	<u>1,775</u>	<u>18,471</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>6,782</u>	<u>9,914</u>	<u>1,775</u>	<u>18,471</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.15%

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?

YesG. 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 53 and days of care provided 1,775Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 8/31/2012 Fiscal Year: 8/31/2012

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

	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	244,358	8,700	10,639	263,697		263,697	(48)	263,649			1
2	Food Purchase		159,176		159,176		159,176	(5,844)	153,332			2
3	Housekeeping	92,011	15,342	572	107,925		107,925		107,925			3
4	Laundry	70,139	7,746		77,885		77,885		77,885			4
5	Heat and Other Utilities			53,166	53,166		53,166		53,166			5
6	Maintenance	49,324	17,918	39,530	106,772		106,772		106,772			6
7	Other (specify):*											7
8	TOTAL General Services	455,832	208,882	103,907	768,621		768,621	(5,892)	762,729			8
	B. Health Care and Programs											
9	Medical Director			4,980	4,980		4,980		4,980			9
10	Nursing and Medical Records	1,155,498	81,451	131,537	1,368,486		1,368,486	(17,860)	1,350,626			10
10a	Therapy			264,963	264,963		264,963		264,963			10a
11	Activities	61,262	2,117	3,904	67,283		67,283	(295)	66,988			11
12	Social Services	23,330	15		23,345		23,345		23,345			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,240,090	83,583	405,384	1,729,057		1,729,057	(18,155)	1,710,902			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			102,672	102,672		102,672		102,672			19
20	Dues, Fees, Subscriptions & Promotions			10,422	10,422		10,422	(2,402)	8,020			20
21	Clerical & General Office Expenses	131,137	36,197	210,796	378,130	(127,398)	250,732	(10,764)	239,968			21
22	Employee Benefits & Payroll Taxes			330,122	330,122		330,122		330,122			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,750	14,750		14,750		14,750			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			29,157	29,157		29,157		29,157			26
27	Other (specify):*											27
28	TOTAL General Administration	131,137	36,197	697,919	865,253	(127,398)	737,855	(13,166)	724,689			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,827,059	328,662	1,207,210	3,362,931	(127,398)	3,235,533	(37,213)	3,198,320			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			75,064	75,064		75,064		75,064			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,751	8,751		8,751	(8,751)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			20,672	20,672		20,672	(1,962)	18,710			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			104,487	104,487		104,487	(10,713)	93,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,814		114,814		114,814	(8,247)	106,567			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,939	32,939	127,398	160,337		160,337			42
43	Other (specify):* See Attachment			1,294,708	1,294,708		1,294,708	(1,294,708)				43
44	TOTAL Special Cost Centers		114,814	1,327,647	1,442,461	127,398	1,569,859	(1,302,955)	266,904			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,827,059	443,476	2,639,344	4,909,879		4,909,879	(1,350,881)	3,558,998			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,844)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,366)	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	(440)	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	(2,702)	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	(33,462)	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	(1,301,067)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,350,881)		\$	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	2	
		Amount	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
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,350,881)		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	2	3	4	
		Yes	No	Amount	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:		9/1/2011
Ending:		8/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	X-Ray - Medicare Expense	\$ (3,795)	39	1
2	Lab - Medicare Expense	(4,452)	39	2
3	Eberhardt Village, Inc. (Assisted Living) Expenses	(1,250,738)	43	3
4	Interest Expense	(8,751)	32	4
5	Grant Revenue	(4,654)	21	5
6	Other Income	(6,110)	21	6
7	Activity Income	(295)	11	7
8	Transportation Income	(17,860)	10	8
9	Advertising Expense	(2,402)	20	9
10	Dietary Income	(48)	1	10
11	Farm Land Rent	(1,962)	34	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	(1,301,067)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(48)	0	0	0	0	0	0	0	0	0	0	(48)	1
2	Food Purchase	(5,844)	0	0	0	0	0	0	0	0	0	0	(5,844)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,892)	0	0	0	0	0	0	0	0	0	0	(5,892)	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	(17,860)	0	0	0	0	0	0	0	0	0	0	(17,860)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(295)	0	0	0	0	0	0	0	0	0	0	(295)	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	(18,155)	0	0	0	0	0	0	0	0	0	0	(18,155)	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	(2,402)	0	0	0	0	0	0	0	0	0	0	(2,402)	20
21	Clerical & General Office Expenses	(10,764)	0	0	0	0	0	0	0	0	0	0	(10,764)	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	(13,166)	0	0	0	0	0	0	0	0	0	0	(13,166)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(37,213)	0	0	0	0	0	0	0	0	0	0	(37,213)	29

Summary B

8/31/2012

[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

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	1/12/2014	4.0000	8,621		6	
7	Private Loan	X		Working Capital	None	6/13/2012	100,000	50,027	6/13/2013	4.0000	130		7	
8													8	
9	TOTAL Facility Related						\$ 400,000	\$ 223,824				\$ 8,751	9	
	B. Non-Facility Related*													
10	USDA		X	Construction	\$24,886.00	3/2/2007	5,721,000	5,721,000	3/1/2047	4.1250	235,991		10	
11	State Bank of Arthur		X	Construction	\$3,845.00	8/27/2008	375,000	317,527	8/27/2023	5.0000	16,713		11	
12	State Bank of Arthur		X	Working Capital	None	5/17/2008	590,000	578,764	1/1/2014	4.0000	23,214		12	
13													13	
14	TOTAL Non-Facility Related				\$28,731.00		\$ 6,686,000	\$ 6,617,291				\$ 275,918	14	
15	TOTALS (line 9+line14)						\$ 7,086,000	\$ 6,841,115				\$ 284,669	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

	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 2011 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 2012 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:	2007 8 2008 9 2009 10 2010 11 2011 12
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	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

The Arthur Home

COUNTY

Moultrie

FACILITY IDPH LICENSE NUMBER

0005462

CONTACT PERSON REGARDING THIS REPORT

David Eversole

TELEPHONE

217-543-2103

FAX #:

217-543-2278

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. Facility pays real estate taxes on		\$	\$
2. non-care assets. All costs are		\$	\$
3. adjusted out of report		\$	\$
4.		\$	\$
5. 03-03-25-406-010	N PT SW 1/4 SE 1/4 Gibson	\$ 678.32	\$
6. 03-03-25-406-011	N PT SW 1/4 SE 1/4 Gibson Add	\$ 66.64	\$
7. 03-03-25-406-012	431 W Palmer Road	\$ 83,204.78	\$
8. 03-03-25-406-013	PT SW 1/4 SE 1/4	\$ 261.62	\$
9. 03-03-25-406-014	PT SW 1/4 SE 1/4	\$ 3.00	\$
10.		\$	\$
TOTALS		\$ 84,214.36	\$

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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	\$ 60,067	1
2					2
3	TOTALS	152,469		\$ 60,067	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		99,895	2,982	Various	2,982		99,895	9
10	1989 Fixed Assets		1989		4,907	196	Various	196		4,606	10
11	1990 Fixed Assets		1990		43,501		Various			43,501	11
12	1992 Fixed Assets		1992		43,861	1,687	Various	1,687		38,646	12
13	1993 Fixed Assets		1993		14,164	708	Various	708		13,461	13
14	1994 Fixed Assets		1994		3,832	192	Various	192		3,540	14
15	1995 Fixed Assets		1995		42,675	2,134	Various	2,134		36,639	15
16	1996 Fixed Assets		1996		7,427	371	Various	371		6,006	16
17	1997 Fixed Assets		1997		45,493	918	Various	918		41,507	17
18	1998 Fixed Assets		1998		23,587	1,164	Various	1,164		16,695	18
19	1999 Fixed Assets		1999		705	35	Various	35		464	19
20	2000 Fixed Assets		2000		1,805	114	Various	114		1,438	20
21	2001 Fixed Assets		2001		8,851	339	Various	339		5,884	21
22	2002 Fixed Assets		2002		28,509	1,425	Various	1,425		14,410	22
23	2003 Fixed Assets		2003		2,653	177	Various	177		1,548	23
24	2004 Fixed Assets		2004		13,501	1,125	Various	1,125		9,122	24
25	2005 Fixed Assets		2005		63,018	3,878	Various	3,878		28,045	25
26	2006 Fixed Assets		2006		7,798	629	Various	629		4,072	26
27	2007 Fixed Assets		2007		20,696	1,654	Various	1,654		8,475	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2011

Ending:

8/31/2012

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	Energy Recovery Ventilator	2008	\$ 1,096	\$ 110	10	\$ 110	\$	\$ 511	37
38	Data Addition	2008	2,737	274	10	274		1,254	38
39	Exterior Light Fixtures	2008	551	55	10	55		252	39
40	Fire Alarm System	2008	1,360	136	10	136		612	40
41	Data Addition	2008	8,137	814	10	814		3,593	41
42	Boiler	2008	612	31	20	31		128	42
43	Chair Rail	2008	528	53	10	53		220	43
44	Air Conditioner	2008	2,726	273	10	273		322	44
45	Code Alert Alarm	2008	790	79	10	79		1,113	45
46	Floor Tile	2008	504	50	10	50		197	46
47	Smoke Shack Floor	2008	625	31	20	31		120	47
48	Door Between AH & Offices	2008	625	31	20	31		117	48
49	Activated Light	2008	561	56	10	56		347	49
50	Sprinkler Heads	2009	992	99	10	99		1,620	50
51	Windows (14) Parkview	2009	6,628	442	15	442		364	51
52	Plumbing	2009	945	95	10	95		206	52
53	Basement Wall	2009	5,604	280	20	280		1,004	53
54	Room Remodel - Room 40	2009	4,923	246	20	246		197	54
55	Sprinkler Heads	2009	1,127	56	20	56		861	55
56	Concrete-Patio	2009	797	40	20	40		100	56
57	Steps-Patio	2009	599	30	20	30		234	57
58	Lights-Hall 20	2009	1,054	70	15	70		133	58
59	Front Porch	2009	1,172	59	20	59		171	59
60	Bathroom Remodeling	2009	1,053	53	20	53		190	60
61	Carpet - Hallway	2009	504	50	10	50		155	61
62	Front Sidewalk	2009	1,125	56	20	56		174	62
63	Fence	2009	4,231	466	10	466		1,785	63
64	Asbestos Inspection	2009	596	199	3	199			64
65	Lumber	2009	529	53	10	53		154	65
66	Wallpaper-Hall 20	2010	2,000	200	10	200		933	66
67	Front Sidewalk	2010	628	63	10	63		141	67
68	Wallpaper Hall 30 & Hall 40	2010	2,654	265	10	265		575	68
69	Wallpaper Hall 50	2010	2,043	204	10	204		307	69
70	TOTAL (lines 4 thru 69)		\$ 970,152	\$ 24,747		\$ 24,747	\$	\$ 829,265	70

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

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	\$ 24,747		\$ 24,747	\$	\$ 829,265	1
2	Wallpaper Hall 60	2011	1,400	140	10	140		210	2
3	Windows Physical Therapy Rm and Multipurpos Rm	2011	2,760	184	15	184		276	3
4	Back Door	2011	3,257	326	10	326		434	4
5	AH Lock Rekeying	2011	2,763	276	10	276		276	5
6	Plumbing-Bathrooms Room 44 & 46	2011	3,677	735	5	735		735	6
7	Carpet - Room 21	2012	706	20	3	20		119	7
8	Panic Device	2012	890	119	5	119		109	8
9	Remodel Room Paint - Hall 60 rooms	2012	558	23	2	23		114	9
10	Room Remodel - Room 42 Sink,Toilet, Bathroom fixtures	2012	975	114	3	114		993	10
11	Sconces - Hallway (both sides)	2012	937	109	3	109		51	11
12	Sprinkler System - Parkview	2012	19,870	993	10	993		23	12
13	Sprinkler Wiring	2012	507	51	3	51		20	13
14	Trees	2011	1,188	178	5	178		178	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)		\$ 1,009,641	\$ 28,015		\$ 28,015	\$	\$ 832,804	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	\$330,942	\$40,149	\$40,149	\$		\$199,081	71
72	Current Year Purchases	32,810	3,558	3,558			3,558	72
73	Fully Depreciated Assets	78,462					78,462	73
74								74
75	TOTALS	\$442,214	\$43,707	\$43,707	\$		\$281,101	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	8,056	78
79										79
80	TOTALS			\$73,613	\$3,350	\$3,350	\$		\$68,269	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)	\$1,585,535	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$75,072	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$75,072	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)	\$1,182,174	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	6,432,452	161,001	656,283	87
88	Assisted Living Grounds	20,690	2,417	7,768	88
89	Assisted Living Vehicles	13,400	3,350	8,056	89
90	Assisted Living Equipment	296,209	22,846	81,609	90
91	TOTALS	\$6,976,751	\$189,614	\$753,716	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.
- ☐ 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: *

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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)	\$			

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		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	\$	1,525	\$ 94,836	\$	1,525	\$ 94,836	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,297	85,078		1,297	85,078	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,406	85,049		1,406	85,049	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			\$	4,228	\$ 264,963	\$	4,228	\$ 264,963	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 47,280	\$ 57,061	1
2	Cash-Patient Deposits	9,688	36,424	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,500)	375,832	374,935	3
4	Supply Inventory (priced at)	9,133	9,921	4
5	Short-Term Investments			5
6	Prepaid Insurance	11,367	15,188	6
7	Other Prepaid Expenses	2,628	4,576	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Trust Receivable</u>	327,688	327,688	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 783,616	\$ 825,793	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	700,201	7,132,653	14
15	Leasehold Improvements, at Historical Cost	309,440	330,130	15
16	Equipment, at Historical Cost	515,827	825,436	16
17	Accumulated Depreciation (book methods)	(1,182,163)	(1,935,879)	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 (specify: <u>Due from Related Entity</u>)	1,474,817		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,878,189	\$ 6,626,407	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,661,805	\$ 7,452,200	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 246,156	\$ 260,874	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,688	36,824	28
29	Short-Term Notes Payable	223,824	802,588	29
30	Accrued Salaries Payable	124,960	147,185	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,470	32
33	Accrued Interest Payable	1,581	965,184	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	60,046	60,046	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 666,255	\$ 2,328,171	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		286,559	39
40	Mortgage Payable		5,751,968	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)	\$	\$ 6,038,527	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 666,255	\$ 8,366,698	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,995,550	\$ (914,498)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,661,805	\$ 7,452,200	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (231,196)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (231,196)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(683,302)	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)	\$ (683,302)	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)	\$ (914,498)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Arthur Home# 0005462Report Period Beginning: 9/1/2011Ending: 8/31/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,292,270	1
2	Discounts and Allowances for all Levels	(285,702)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,006,568	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,373	6
7	Oxygen	37,974	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 321,347	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	5,844	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	101,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,106	19
20	Radiology and X-Ray	5,457	20
21	Other Medical Services	1,929	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 119,808	23
	D. Non-Operating Revenue		
24	Contributions	16,076	24
25	Interest and Other Investment Income***	26,447	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,523	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Assisted Living Revenue	707,013	28
28a	See attached schedule	29,318	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 736,331	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,226,577	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	768,621	31
32	Health Care	1,729,057	32
33	General Administration	865,253	33
	B. Capital Expense		
34	Ownership	104,487	34
	C. Ancillary Expense		
35	Special Cost Centers	114,814	35
36	Provider Participation Fee	32,939	36
	D. Other Expenses (specify):		
37	Non-Allowable AL & Other Expenses	1,294,708	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,909,879	40
41	Income before Income Taxes (line 30 minus line 40)**	(683,302)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (683,302)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 769,606	44
45	Private Pay - Net Inpatient Revenue	1,791,236	45
46	Medicare - Net Inpatient Revenue	445,726	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,006,568	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.

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	1,784	1,990	\$ 65,043	\$ 32.68	1
2	Assistant Director of Nursing	1,800	1,942	49,390	25.43	2
3	Registered Nurses	5,589	6,151	152,499	24.79	3
4	Licensed Practical Nurses	14,716	16,249	325,509	20.03	4
5	CNAs & Orderlies	40,241	43,672	507,878	11.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,741	4,049	55,179	13.63	8
9	Activity Director	1,648	1,910	26,244	13.74	9
10	Activity Assistants	3,632	3,919	35,018	8.94	10
11	Social Service Workers	1,623	2,004	23,330	11.64	11
12	Dietician					12
13	Food Service Supervisor	1,360	1,560	19,896	12.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,236	22,626	224,462	9.92	15
16	Dishwashers					16
17	Maintenance Workers	3,276	3,404	49,324	14.49	17
18	Housekeepers	7,546	8,279	92,011	11.11	18
19	Laundry	6,030	6,566	70,139	10.68	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	4,808	5,391	89,616	16.62	22
23	Office Manager	1,807	2,024	41,521	20.51	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)	120,837	131,736	\$ 1,827,059 *	\$ 13.87	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	98	\$ 5,108	1-3	35
36	Medical Director	Monthly	4,980	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	16	3,379	10-3	38
39	Pharmacist Consultant	60	2,090	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	200	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	1,261	11-3	44
45	Social Service Consultant	18	1,261	11-3	45
46	Other(specify) <u>Dental</u>	12	1,380	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	226	\$ 19,659		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	162	\$ 7,479	10-3	50
51	Licensed Practical Nurses	283	10,860	10-3	51
52	Certified Nurse Assistants/Aides	2,664	63,945	10-3	52
53	TOTAL (lines 50 - 52)	3,109	\$ 82,284		53

STATE OF ILLINOIS

0005462

Report Period Beginning:

9/1/2011

Page 21

Ending: 8/31/2012

Facility Name & ID Number

The Arthur Home

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 48,642	IDPH License Fee	\$	
				Unemployment Compensation Insurance	6,053	Advertising: Employee Recruitment	3,106	
				FICA Taxes	136,516	Health Care Worker Background Check		
				Employee Health Insurance	123,234	(Indicate # of checks performed 16)	448	
				Employee Meals		Patient Background Checks	41	
				Illinois Municipal Retirement Fund (IMRF)*		Vehicle License	119	
						Fundraising and Volunteering	134	
				Other Employee Benefits	(398)	Dues	2,222	
				Pension Contributions	16,075	Other Licenses	2,973	
						Other Taxes	1,010	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(2,402)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
CliftonLarsonAllen LLP	Accounting	\$ 17,938			\$	Out-of-State Travel	\$ 3,056	
Samuels, Miller, Lee Law	Legal	285						
Polisnelli	Legal	10,211						
Greencroft Communities	Management Fees	74,238				In-State Travel	5,863	
						Seminar Expense	5,831	
						Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 102,672			TOTAL		
						\$ 14,750		

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$1,722; Leading Age \$979

(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.

\$

18,554

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.

\$

160,337

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.

\$

5,844

(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:

CliftonLarsonAllen 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.