

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

<p>I. IDPH License ID Number: <u>0046755</u></p> <p>Facility Name: <u>Oakview</u></p> <p>Address: <u>2311 Veterans Drive</u> <u>Effingham</u> <u>62401</u> Number City Zip Code</p> <p>County: <u>Effingham</u></p> <p>Telephone Number: <u>(217) 342-6400</u> Fax # <u>(217) 342-6412</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/24/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501(c)(3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2012</u> to <u>06/30/2013</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) _____</td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>		(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number Oakview

0046755 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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 N/A

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,394</u>			<u>5,394</u>
14	TOTALS	<u>5,394</u>			<u>5,394</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.36%

D. How many bed-hold days during this year were paid by the Department? 127 (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 03/24/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/24/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name & ID Number

Oakview

0046755

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

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	86,708	5,027	550	92,285		92,285	1,389	93,674		1
2	Food Purchase		49,505		49,505		49,505	(6,375)	43,130		2
3	Housekeeping	14,519	7,922		22,441		22,441		22,441		3
4	Laundry	9,679	2,900		12,579		12,579		12,579		4
5	Heat and Other Utilities			11,563	11,563		11,563		11,563		5
6	Maintenance	2,666	9,637	2,715	15,018		15,018		15,018		6
7	Other (specify):*										7
8	TOTAL General Services	113,572	74,990	14,828	203,390		203,390	(4,986)	198,404		8
	B. Health Care and Programs										
9	Medical Director							2,250	2,250		9
10	Nursing and Medical Records	3,603	7,349	12,139	23,091		23,091	(2,250)	20,841		10
10a	Therapy										10a
11	Activities	135,962	2,746		138,708		138,708		138,708		11
12	Social Services		9		9		9		9		12
13	CNA Training										13
14	Program Transportation		9,920		9,920		9,920		9,920		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	139,565	20,025	12,139	171,729		171,729		171,729		16
	C. General Administration										
17	Administrative	48,747			48,747		48,747		48,747		17
18	Directors Fees										18
19	Professional Services			4,500	4,500		4,500		4,500		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	25,325	7,019	4,572	36,916		36,916	(340)	36,576		21
22	Employee Benefits & Payroll Tax			93,403	93,403		93,403	6,375	99,778		22
23	Inservice Training & Education			208	208		208		208		23
24	Travel and Seminar			154	154		154		154		24
25	Other Admin. Staff Transportator		321		321		321		321		25
26	Insurance-Prop.Liab.Malpractice			1,240	1,240		1,240		1,240		26
27	Other (specify):* Indirect Costs			35,152	35,152		35,152		35,152		27
28	TOTAL General Administration	74,072	7,340	139,229	220,641		220,641	6,035	226,676		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	327,209	102,355	166,196	595,760		595,760	1,049	596,809		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 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
	D. Ownership										
30	Depreciation			1,560	1,560	1,560	31,603	33,163			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			71	71	71	12,122	12,193			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds			88,580	88,580	88,580	(88,580)	(0)			34
35	Rent-Equipment & Vehicles						340	340			35
36	Other (specify):*										36
37	TOTAL Ownership			90,211	90,211	90,211	(44,515)	45,696			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportator										38
39	Ancillary Service Centers		179	365	544	544		544			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shop:										41
42	Provider Participation Fee			38,340	38,340	38,340		38,340			42
43	Other (specify):* Non-Allowable Cos			182	182	182	(182)	(0)			43
44	TOTAL Special Cost Centers		179	38,887	39,066	39,066	(182)	38,884			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	327,209	102,534	295,294	725,037	725,037	(43,648)	681,389			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				4
5	Telephone, TV & Radio in Resident Room:				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,719)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund:				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer:				22
23	Malpractice Insurance for Individual:				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employee:				27
28	Yellow Page Advertising	(180)	43		28
29	Other-Attach Schedule	1,389	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,510)		\$	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)	(40,136)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (40,136)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (43,646)		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		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Oakview

Report Period Beginning: 07/01/2012
 Ending: 06/30/2013

ID# 0046755

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Dietary Assets Expensed instead of capitalized	\$ 1,389	1	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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		1,389	49

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
ARC-Community Support Systems, Inc.	100	N/A		Merchant	Effingham	CILA
				KC Home	Effingham	CILA
				Smith	Teutopolis	CILA
				DT Center	Teutopolis	Developmental Training
				ARC-Community Support Systems Foundation, Inc.	Teutopolis	Lessor

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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	30 Depreciation	\$	ARC-Community Support Systems Foundation, Inc.	0.00%	\$ 36,322	\$	36,322	1
2	V	32 Interest Expense		ARC-Community Support Systems Foundation, Inc.	0.00%	12,122		12,122	2
3	V	34 Rent	88,580	ARC-Community Support Systems Foundation, Inc.	0.00%			(88,580)	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		\$ 88,580			\$ 48,444	\$ *	(40,136)	14

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

Facility Name & ID Number

Oakview

#

0046755

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	See attached list of Board of Directors.		Management	0.00	0	See Sch 17A			\$ 0	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Oakview

0046755 Report Period Beginning: 07/01/2012

Ending: 6/30/2013

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5		N/A							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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Teutopolis State Bank		X	Facility	\$5,500.00	02/02/11	\$ 860,000	\$ 256,124	02/02/16	0.0425	\$ 12,122	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$5,500.00		\$ 860,000	\$ 256,124			\$ 12,122	9				
B. Non-Facility Related*																
10												10				
11									State - Interest Reimburse.			71				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 71	14				
15	TOTALS (line 9+line14)						\$ 860,000	\$ 256,124			\$ 12,193	15				

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

* 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 2012 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.)		2012		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2013 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	2008	_____	8	FOR BHF USE ONLY	
	2009	_____	9		
	2010	_____	10	13	FROM R. E. TAX STATEMENT FOR 2012 \$
	2011	_____	11	14	PLUS APPEAL COST FROM LINE 5 \$
	2012	N/A	12	15	LESS REFUND FROM LINE 6 \$
Facility is a not for profit entity and does not pay real estate tax.					
				16	AMOUNT TO USE FOR RATE CALCULATION \$

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.**

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakview COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0046755

CONTACT PERSON REGARDING THIS REPORT Mike Poe

TELEPHONE (618) 857-3186 FAX #: (618) 857-6343

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>Facility is a not for profit entity and</u>	<u>does not pay real estate tax.</u>	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	N/A	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Oakview

0046755 Report Period Beginning:

07/01/2012 Ending:

06/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,200 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>63,000</u>	<u>2004</u>	<u>\$ 95,244</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	63,000		\$ 95,244	3

Facility Name & ID Number Oakview

0046755

Report Period Beginning:

07/01/2012 Ending:

06/30/2013

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	2005	2005	\$ 1,113,035	\$	40	\$ 27,826	\$ 27,826	\$ 229,565	4
5		2005	2005	5,462		40	137	137	1,096	5
6										6
7										7
8										8
Improvement Type**										
9	Wall and window hangings, drapes, decorating		2005	5,521	552	10	552		4,549	9
10	Telephone system upgrade		2005	450	45	10	45		371	10
11										11
12										12
13	Landscaping Improvements		2005	957		10	96	96	768	13
14	Fire Sprinklers		2005	10,359	636	10	1,036	400	8,288	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

*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 Oakview

0046755

Report Period Beginning:

07/01/2012 Ending: 06/30/2013

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		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	1,135,784	\$	1,233	\$	29,692	\$	28,459	\$	244,637	70

**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	\$ 43,414	\$ 327	\$ 3,471	\$ 3,144		\$ 36,552	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	895					895	73
74								74
75	TOTALS	\$ 44,309	\$ 327	\$ 3,471	\$ 3,144		\$ 37,447	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 Use	2002 Ford Van	2005	\$ 11,981	\$	\$	\$	5	\$ 11,981	76
77										77
78										78
79										79
80	TOTALS			\$ 11,981	\$	\$	\$		\$ 11,981	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)	\$ 1,287,318	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,560	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,163	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,603	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 294,065	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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:			\$ <u>N/A</u>			3
4	Additions						4
5							5
6							6
7	TOTAL			\$			7

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.	<u>/2014</u>	\$ _____
-----	--------------	----------

13.	<u>/2015</u>	\$ _____
-----	--------------	----------

14.	<u>/2016</u>	\$ _____
-----	--------------	----------

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 _____.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 340 Description: Copier - \$340

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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.)

	Service	1 Schedule V Line & Column Reference	2		4	5	6	7	8						
			Staff								Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost							Units	Cost			
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1					
2	Licensed Speech and Language Development Therapist		hrs							2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	39(2)	hrs				179		179	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy		# of prescripts							9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Other (specify): <u>Day Training Trans</u>	39(3)					365		365	12					
13	Other (specify):									13					
14	TOTAL			\$		\$	544	\$	544	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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		95,244	13
14	Buildings, at Historical Cost		1,118,497	14
15	Leasehold Improvements, at Historical Cost		17,287	15
16	Equipment, at Historical Cost		56,290	16
17	Accumulated Depreciation (book methods)		(294,065)	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)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 993,253	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ SEE SCH 17A	\$ SEE SCH 17A	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		256,124	39
40	Mortgage Payable			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)	\$	\$ 256,124	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 256,124	46
47	TOTAL EQUITY(page 18, line 24)	\$ SEE SCH 17A	\$ SEE SCH 17A	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ SEE SCH 17A	\$ SEE SCH 17A	48

*(See instructions.)

Oakview
Provider #: 0046755
FYE: 06/30/2013

SCHEDULE 17A

NOTE: Oakview is a 16-bed DD facility that is part of ARC - Community Support Systems (ARC-CSS), a multi-program organization. ARC-CSS combines all its programs in a single balance sheet; therefore, it does not maintain separate Balance Sheets or Statements of Equity for each program. For this reason, pages 17 & 18 have not been completed on this cost report.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies	N/A	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 Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	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)	\$ SEE SCH 17A	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 479,428	1
2	Discounts and Allowances for all Level	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 479,428	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)		8
C. Other Operating Revenue			
9	Payments for Educator		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		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space	125,240	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 125,240	23
D. Non-Operating Revenue			
24	Contributions	1,078	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,078	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 605,746	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	203,390	31
32	Health Care	171,729	32
33	General Administration	220,641	33
B. Capital Expense			
34	Ownership	90,211	34
C. Ancillary Expense			
35	Special Cost Centers	726	35
36	Provider Participation Fee	38,340	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 725,037	40
41	Income before Income Taxes (line 30 minus line 40)**	(119,291)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (119,291)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 479,428	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 479,428	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Oakview

0046755

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

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
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	172	3,603	20.95	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician	4,628	55,656	12.03	12
13	Food Service Supervisor				13
14	Head Cook	2,443	31,052	12.71	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	205	2,666	13.00	17
18	Housekeepers	1,226	14,519	11.84	18
19	Laundry	810	9,679	11.95	19
20	Administrator	1,591	38,346	24.10	20
21	Assistant Administrator				21
22	Other Administrative	212	10,401	49.06	22
23	Office Manager				23
24	Clerical	1,251	25,325	20.24	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)	10,692	135,962	12.72	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)		23,230	\$ 327,209 *	\$ 14.09 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	28	\$ 550	1(3) 35
36	Medical Director	9	2,250	7(3) 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	37	\$ 2,800	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	409	\$ 9,889	10(3) 50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	409	\$ 9,889	53

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		
Barb Rodgers	Administrator		\$ 38,695	Workers' Compensation Insurance	\$ 9,766	IDPH License Fee	\$		
Other Admin	Administrative		10,052	Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes	23,490	Health Care Worker Background Check			
				Employee Health Insurance	47,096	(Indicate # of checks performed _____)			
				Employee Meals	6,375	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Page Advertising	180		
				Employee 401 (k)	12,879				
				Employee Disability	171				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,747	TOTAL (agree to Schedule V, line 22, col.8)		\$ 99,777			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	154	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 154
C. Professional Services									
Vendor/Payee	Type		Amount						
McGladrey LLP	Accounting		\$ 4,500						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,500						

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3										N/A		
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

