

Facility Name & ID Number The Arthur Home

0005462 Report Period Beginning: 9/1/2014 Ending: 8/31/2015

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 7/7/2012

	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>53</u>	Skilled (SNF)	<u>53</u>	<u>19,345</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>53</u>	TOTALS	<u>53</u>	<u>19,345</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>4,684</u>	<u>8,910</u>	<u>2,365</u>	<u>15,959</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>4,684</u>	<u>8,910</u>	<u>2,365</u>	<u>15,959</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.50%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/1/1958

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 53 and days of care provided 2,365

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/2015 Fiscal Year: 8/31/2015

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

Facility Name & ID Number

The Arthur Home

0005462

Report Period Beginning:

9/1/2014

Ending:

8/31/2015

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	180,512	6,444	9,449	196,405		196,405		196,405		1
2	Food Purchase		156,852		156,852		156,852	(3,864)	152,988		2
3	Housekeeping	97,935	13,659	680	112,274		112,274		112,274		3
4	Laundry	61,011	8,646		69,657		69,657		69,657		4
5	Heat and Other Utilities			38,325	38,325		38,325		38,325		5
6	Maintenance	63,107	23,088	45,879	132,074		132,074		132,074		6
7	Other (specify):*										7
8	TOTAL General Services	402,565	208,689	94,333	705,587		705,587	(3,864)	701,723		8
	B. Health Care and Programs										
9	Medical Director			14,208	14,208		14,208		14,208		9
10	Nursing and Medical Records	1,100,758	126,902	57,606	1,285,266		1,285,266	(21,848)	1,263,418		10
10a	Therapy			331,735	331,735		331,735		331,735		10a
11	Activities	50,548	3,982	4,823	59,353		59,353	(63)	59,290		11
12	Social Services	24,322	35		24,357		24,357		24,357		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,175,628	130,919	408,372	1,714,919		1,714,919	(21,911)	1,693,008		16
	C. General Administration										
17	Administrative	78,937			78,937		78,937		78,937		17
18	Directors Fees										18
19	Professional Services			35,417	35,417		35,417		35,417		19
20	Dues, Fees, Subscriptions & Promotions			24,999	24,999		24,999		24,999		20
21	Clerical & General Office Expenses	127,796	10,823	99,584	238,203		238,203	(23,917)	214,286		21
22	Employee Benefits & Payroll Taxes			246,804	246,804		246,804		246,804		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,150	16,150		16,150		16,150		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			33,071	33,071		33,071		33,071		26
27	Other (specify):*										27
28	TOTAL General Administration	206,733	10,823	456,025	673,581		673,581	(23,917)	649,664		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,784,926	350,431	958,730	3,094,087		3,094,087	(49,692)	3,044,395		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

The Arthur Home

#0005462

Report Period Beginning:

9/1/2014

Ending:

8/31/2015

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			72,183	72,183		72,183		72,183			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145,635	145,635		145,635	(85,975)	59,660			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			20,672	20,672		20,672	(2,992)	17,680			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			238,490	238,490		238,490	(88,967)	149,523			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,984		116,984		116,984	(84,932)	32,052			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,942	113,942		113,942		113,942			42
43	Other (specify):* Assisted Living	382,088		549,023	931,111		931,111	(910,531)	20,580			43
44	TOTAL Special Cost Centers	382,088	116,984	662,965	1,162,037		1,162,037	(995,463)	166,574			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,167,014	467,415	1,860,185	4,494,614		4,494,614	(1,134,122)	3,360,492			45

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

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0005462

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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	(3,864)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,353)	21		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	(132)	21		13
14	Non-Care Related Interest	(85,975)	32		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	(2,559)	21		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	(9,272)	21		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 See Page5A	(1,023,967)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,134,122)		\$	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)	(720)	VII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (720)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,134,842)		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: 9/1/2014

Ending: 8/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	X-Ray - Medicare Expense	\$ (7,997)	39	1
2	Lab - Medicare Expense	(3,190)	39	2
3	Eberhardt Village, Inc. (Assisted Living) Expenses	(910,531)	43	3
4	Other Income	(509)	21	4
5	Transportation Income	(21,848)	10	5
6	Farm Land Rent	(2,992)	34	6
7	Activity Income	(63)	11	7
8	Advertising Expense	(2,250)	21	8
9	Other Taxes	(842)	21	9
10				10
11				11
12				12
13	Pharmacy - Medicare Expense	(73,745)	39	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	(1,023,967)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arthur Home# 0005462

Report Period Beginning:

9/1/2014

Ending:

8/31/2015

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,864)	0	0	0	0	0	0	0	0	0	0	(3,864)	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	(3,864)	0	(3,864)	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	(21,848)	0	0	0	0	0	0	0	0	0	0	(21,848)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(63)	0	0	0	0	0	0	0	0	0	0	(63)	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	(21,911)	0	(21,911)	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(23,917)	0	0	0	0	0	0	0	0	0	0	(23,917)	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	(23,917)	0	(23,917)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,692)	0	(49,692)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arthur Home# 0005462

Report Period Beginning:

9/1/2014 Ending:

8/31/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(85,975)	0	0	0	0	0	0	0	0	0	0	(85,975)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,992)	0	0	0	0	0	0	0	0	0	0	(2,992)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(88,967)	0	0	0	0	0	0	0	0	0	0	(88,967)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(84,932)	0	0	0	0	0	0	0	0	0	0	(84,932)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(910,531)	0	0	0	0	0	0	0	0	0	0	(910,531)	43
44	TOTAL Special Cost Centers	(995,463)	0	0	0	0	0	0	0	0	0	0	(995,463)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,134,122)	0	0	0	0	0	0	0	0	0	0	(1,134,122)	45

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2014

Ending:

8/31/2015

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	Maintenance	\$ 720	Henry Herschberger - Board Member	0.00%	\$ 720	\$	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		\$ 720			\$ 720	\$ *	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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See attached listing of board members. No board members receive compensation.							\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

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

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

Facility Name & ID Number The Arthur Home

0005462 Report Period Beginning: 9/1/2014 Ending: 3/31/2015

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

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

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

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

Facility Name & ID Number

The Arthur Home

0005462

Report Period Beginning:

9/1/2014

Ending:

8/31/2015

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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	First Mid-Illinois Bank		X	Real Estate Finance	None	1/5/2015	\$ 1,325,000	\$ 1,254,115	1/1/2018	4.2500	\$ 38,783						
2																	
3																	
4																	
5																	
Working Capital																	
6	State Bank of Arthur		X	Working Capital	None	8/30/2006	300,000		11/1/2015	4.0000	4,347						
7	Private Loan	X		Working Capital	None	6/13/2013	500,000	456,001	6/13/2015	4.0000	6,001						
8	Private Loan	X		Working Capital	None	8/30/2013	200,000	200,392	8/30/2015	5.0000	10,529						
9	TOTAL Facility Related						\$ 2,325,000	\$ 1,910,508			\$ 59,660						
B. Non-Facility Related*																	
10	USDA		X	Construction	\$9,550.00	3/2/2007	5,721,000		3/1/2047	4.1250	78,664						
11	State Bank of Arthur		X	Construction	\$3,845.00	8/27/2008	375,000		8/27/2023	4.2500							
12	State Bank of Arthur		X	Working Capital	None	5/17/2008	590,000		1/1/2015	4.0000	7,311						
13																	
14	TOTAL Non-Facility Related				\$13,395.00		\$ 6,686,000	\$			\$ 85,975						
15	TOTALS (line 9+line14)						\$ 9,011,000	\$ 1,910,508			\$ 145,635						

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

		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 2014 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 2015 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:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2014 \$		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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arthur Home COUNTY Moultrie
 FACILITY IDPH LICENSE NUMBER 0005462
 CONTACT PERSON REGARDING THIS REPORT Lashelle Plank
 TELEPHONE 217-543-4551 FAX #: 217-543-2278

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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 pays real estate taxes on</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
2. <u>non-care assets. All costs are</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
3. <u>adjusted out of report</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
4. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
5. <u>03-03-25-425-010</u>	<u>N PT SW 1/4 SE 1/4 Gibson</u>	\$ <u>667.58</u>	\$ <u>_____</u>
6. <u>03-03-25-425-011</u>	<u>N PT SW 1/4 SE 1/4 Gibson Add</u>	\$ <u>91.10</u>	\$ <u>_____</u>
7. <u>03-03-25-406-020</u>	<u>431 W Palmer Road</u>	\$ <u>67,134.06</u>	\$ <u>_____</u>
8. <u>03-03-25-406-017</u>	<u>PT SW 1/4 SE 1/4</u>	\$ <u>298.78</u>	\$ <u>_____</u>
9. <u>03-03-25-406-014</u>	<u>PT SW 1/4 SE 1/4</u>	\$ <u>6.00</u>	\$ <u>_____</u>
10. <u>03-03-25-406-021</u>	<u>PT SW 1/4 SE 1/4</u>	\$ <u>7.90</u>	\$ <u>_____</u>
TOTALS		\$ <u><u>68,205.42</u></u>	\$ <u><u>_____</u></u>

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 The Arthur Home

0005462 Report Period Beginning:

9/1/2014 Ending:

8/31/2015

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>152,469</u>	<u>1959</u>	<u>\$ 50,084</u>	1
2					2
3	TOTALS	152,469		\$ 50,084	3

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2014

Ending:

8/31/2015

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	25	1959	1959	\$ 124,966	\$	33	\$	\$	\$ 124,966
5	28	1975	1975	308,252		33			308,252
6									
7									
8									
Improvement Type**									
9	1987 Fixed Assets		1987	99,897					99,897
10	1989 Fixed Assets		1989	4,907					4,907
11	1990 Fixed Assets		1990	43,501					43,501
12	1992 Fixed Assets		1992	43,861	1,136		1,136		42,103
13	1993 Fixed Assets		1993	14,164					14,164
14	1994 Fixed Assets		1994	3,832					3,832
15	1995 Fixed Assets		1995	42,675	1,769		1,769		42,675
16	1996 Fixed Assets		1996	7,427	371		371		7,120
17	1997 Fixed Assets		1997	45,493	918		918		44,259
18	1998 Fixed Assets		1998	23,587	1,164		1,164		20,185
19	1999 Fixed Assets		1999	705	35		35		570
20	2000 Fixed Assets		2000	1,805	52		52		1,717
21	2001 Fixed Assets		2001	8,851	339		339		6,901
22	2002 Fixed Assets		2002	28,509	1,425		1,425		18,686
23	2003 Fixed Assets		2003	2,653	177		177		2,078
24	2004 Fixed Assets		2004	13,501	494		494		11,683
25	2005 Fixed Assets		2005	63,018	3,731		3,731		39,531
26	2006 Fixed Assets		2006	7,798	629		629		5,959
27	2007 Fixed Assets		2007	20,696	1,654		1,654		13,435
28	2008 Fixed Assets		2008	20,290	1,936		1,936		14,247
29	2009 Fixed Assets		2009	32,440	2,151		2,151		14,150
30									
31									
32									
33									
34									
35									
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:

9/1/2014

Ending:

8/31/2015

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wall Paper - Hallways	2010	\$ 2,000	\$ 267		\$ 267	\$	\$ 2,000	37
38	Front Sidewalk - Front Door	2010	628	63		63		330	38
39	Wallpaper ParkView	2010	2,654	265		265		1,371	39
40	Wallpapering-LakeView	2011	1,400	140		140		630	40
41	Wallpaper-LakeView	2011	2,043	204		204		919	41
42	Windows (8)Parkview	2011	2,760	184		184		828	42
43	BACK DOOR - Arthur Home	2011	3,257	326		326		1,412	43
44	AH Lock Rekeving - Arthur Home	2011	2,763	276		276		1,105	44
45	Plumbing - Basement	2011	3,677	735		735		2,941	45
46	Trees	2011	1,188	237		237		890	46
47	Panic Device	2012	890	178		178		653	47
48	Sconces - Hallways	2012	937	187		187		671	48
49	Room Remodel - Room 42	2012	975	195		195		699	49
50	Sprinkler System-Parkview	2012	19,870	1,987		1,987		6,954	50
51	Sprinklers Wiring	2012	507	101		101		355	51
52	Remodel Room Paint - Various Rooms	2012	558					558	52
53	Carpet - Room 21	2012	706	215		215		706	53
54	Fire Doors Between 40&50	2013	5,276	1,055		1,055		2,813	54
55	Floor Work - Hallway between 30 & 60	2013	685	228		228		589	55
56	Floor Work - Hallway between 30 & 60	2013	308	103		103		266	56
57	Relocate Dry Pendants - Crawl space	2013	3,637	1,212		1,212		3,131	57
58	Carpet - Room 35	2013	792	264		264		594	58
59	Carpet - Room 37	2013	1,109	370		370		832	59
60	Shower Room Floor	2014	3,198						60
61	To Tie to FS		(1)					1,760	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,024,645	\$ 26,775		\$ 26,775	\$	\$ 917,827	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	\$ 260,469	\$ 27,752	\$ 27,752	\$	VAR	\$ 135,172	71
72	Current Year Purchases	29,617	3,255	3,255		VAR	3,255	72
73	Fully Depreciated Assets	262,488	7,608	7,608		VAR	262,488	73
74	To Tie to FS	(2,852)	6,793	6,793			801	74
75	TOTALS	\$ 549,722	\$ 45,408	\$ 45,408	\$		\$ 401,716	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	1991	\$ 15,110	\$	\$	\$	5	\$ 15,110	76
77	Resident Care	Handicap Bus	2001	45,103				5	45,103	77
78	Resident Care	2004 Toyota Sienna	2010	5,750				4	5,750	78
79	Resident Care	Van Conversion	2010	7,650				4	7,650	79
80	TOTALS			\$ 73,613	\$	\$	\$		\$ 73,613	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)	\$ 1,698,064	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,183	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,183	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)	\$ 1,393,156	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	6,453,958	22,678	5,489,431	87
88	Assisted Living Grounds				88
89	Assisted Living Vehicles	13,400		13,400	89
90	Assisted Living Equipment	334,578	18,518	239,761	90
91	TOTALS	\$ 7,015,936	\$ 41,196	\$ 5,742,592	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

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>/2016</u>	\$ _____
13.	<u>/2017</u>	\$ _____
14.	<u>/2018</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 _____.

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

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

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2014 Ending: 8/31/2015
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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>CNA's must be trained before hired.</u></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		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	2,364	\$ 105,668	\$	2,364	\$ 105,668	1	
2	Licensed Speech and Language Development Therapist	10A-3	hrs	_____	2,209	98,900		2,209	98,900	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A-3	hrs		2,801	127,167		2,801	127,167	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): _____									12	
13	Other (specify): _____									13	
14	TOTAL			\$	7,374	\$ 331,735	\$	7,374	\$ 331,735	14	

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

Facility Name & ID Number The Arthur Home# 0005462Report Period Beginning: 9/1/2014

Ending:

8/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2015

(last day of reporting year)

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	\$ 244,296	\$	1
2	Cash-Patient Deposits	26,463		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>386,729</u>)	503,576		3
4	Supply Inventory (priced at)	15,481		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,859		6
7	Other Prepaid Expenses	8,755		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Contributions Receivable</u>	304,451		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,115,881	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	264,084		13
14	Buildings, at Historical Cost	7,169,163		14
15	Leasehold Improvements, at Historical Cost	309,440		15
16	Equipment, at Historical Cost	971,313		16
17	Accumulated Depreciation (book methods)	(7,135,747)		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)	\$ 1,578,253	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,694,134	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 469,322	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,405		28
29	Short-Term Notes Payable	456,001		29
30	Accrued Salaries Payable	162,744		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,208		31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,701		32
33	Accrued Interest Payable	13,354		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Other Accrued Expenses</u>	32,027		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,274,762	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,454,507		39
40	Mortgage Payable	44,048		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Asset Retirement Obligation</u>	85,290		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,583,845	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,858,607	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (164,473)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,694,134	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,508,499)	1
2	Restatements (describe):		2
3	2014 Net Assets as restated	(5,114,760)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,623,259)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	6,458,786	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)	\$ 6,458,786	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)	\$ (164,473)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Arthur Home# 0005462Report Period Beginning: 9/1/2014Ending: 8/31/2015

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	\$ 3,660,303	1
2	Discounts and Allowances for all Levels	(762,380)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,897,923	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	381,042	6
7	Oxygen	24,237	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 405,279	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	3,864	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,763	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,265	19
20	Radiology and X-Ray	3,806	20
21	Other Medical Services	29,143	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 151,841	23
D. Non-Operating Revenue			
24	Contributions	17,064	24
25	Interest and Other Investment Income***	(12,954)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,110	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Assisted Living Revenue	7,468,835	28
28a	Miscellaneous See Grouping Report IS28A Detail	25,412	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,494,247	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,953,400	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	705,587	31
32	Health Care	1,714,919	32
33	General Administration	673,581	33
B. Capital Expense			
34	Ownership	238,490	34
C. Ancillary Expense			
35	Special Cost Centers	116,984	35
36	Provider Participation Fee	113,942	36
D. Other Expenses (specify):			
37	<u>Assisted Living</u>	931,111	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,494,614	40
41	Income before Income Taxes (line 30 minus line 40)**	6,458,786	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 6,458,786	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,182,594	44
45	Private Pay - Net Inpatient Revenue	1,042,396	45
46	Medicare - Net Inpatient Revenue	672,933	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,897,923	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 The Arthur Home

0005462

Report Period Beginning:

9/1/2014

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8/31/2015

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	2,101	2,249	\$ 70,794	\$ 31.48	1
2	Assistant Director of Nursing	725	733	21,193	28.91	2
3	Registered Nurses	2,847	2,883	71,157	24.68	3
4	Licensed Practical Nurses	14,896	15,737	326,421	20.74	4
5	CNAs & Orderlies	39,632	42,403	490,030	11.56	5
6	CNA Trainees	-	-	-	-	6
7	Licensed Therapist	4,537	5,385	67,068	12.45	7
8	Rehab/Therapy Aides	-	-	-	-	8
9	Activity Director	1,789	2,027	26,842	13.24	9
10	Activity Assistants	1,941	2,177	23,706	10.89	10
11	Social Service Workers	1,898	2,054	24,322	11.84	11
12	Dietician	-	-	-	-	12
13	Food Service Supervisor	1,981	2,160	23,264	10.77	13
14	Head Cook	-	-	-	-	14
15	Cook Helpers/Assistants	14,408	15,449	157,248	10.18	15
16	Dishwashers	-	-	-	-	16
17	Maintenance Workers	5,011	5,273	63,107	11.97	17
18	Housekeepers	8,031	8,993	97,935	10.89	18
19	Laundry	5,098	5,522	61,011	11.05	19
20	Administrator	1,691	2,021	78,937	39.06	20
21	Assistant Administrator	-	-	-	-	21
22	Other Administrative	7,733	8,557	127,796	14.93	22
23	Office Manager	-	-	-	-	23
24	Clerical	-	-	-	-	24
25	Vocational Instruction	-	-	-	-	25
26	Academic Instruction	-	-	-	-	26
27	Medical Director	-	-	-	-	27
28	Qualified MR Prof. (QMRP)	-	-	-	-	28
29	Resident Services Coordinator	-	-	-	-	29
30	Habilitation Aides (DD Homes)	-	-	-	-	30
31	Medical Records	-	-	-	-	31
32	Other Health C: MDS/Quality Assu	2,156	2,521	54,096	21.46	32
33	Other(specify) <u>Assisted Living</u>	19,707	21,280	382,087	17.96	33
34	TOTAL (lines 1 - 33)	136,182	147,424	\$ 2,167,014 *	\$ 14.70	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	100	\$ 4,862	1-3	35
36	Medical Director	Monthly	14,208	9-3	36
37	Medical Records Consultant	Monthly	3,508	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,328	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,838	11-3	44
45	Social Service Consultant	Monthly	1,838	11-3	45
46	Other(specify) <u>Dental Consultant</u>	Monthly	1,080	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	196	\$ 28,662		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	63	\$ 2,567	10-3	50
51	Licensed Practical Nurses	168	5,995	10-3	51
52	Certified Nurse Assistants/Aides	1,855	41,964	10-3	52
53	TOTAL (lines 50 - 52)	2,086	\$ 50,526		53

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	This workpaper is N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number The Arthur Home# 0005462

Report Period Beginning:

9/1/2014

Ending:

8/31/2015**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 \$3,724.11 / Leading Age \$823.00
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,978 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 113,942
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,864
- (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? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.