



Facility Name & ID Number Elizabeth Nursing Home

# 0008300 Report Period Beginning: 01/01/16 Ending: 12/31/16

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	15,006	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	15,006	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	4,862	6,670		11,532	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,862	6,670		11,532	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.85%**

**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)**

Assisted Living Facility, Rental of Clinic Space

**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 07/08/1968

**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 \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/16 Ending: 12/31/16

**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
	<b>A. General Services</b>										
1	Dietary	138,381	85,615		223,996		223,996		223,996		1
2	Food Purchase		123,668		123,668		123,668	(2,253)	121,415		2
3	Housekeeping	36,385			36,385		36,385		36,385		3
4	Laundry	23,486			23,486		23,486		23,486		4
5	Heat and Other Utilities										5
6	Maintenance	23,524	25,870	135,304	184,698		184,698		184,698		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	221,776	235,153	135,304	592,233		592,233	(2,253)	589,980		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	788,566	313		788,879		788,879		788,879		10
10a	Therapy										10a
11	Activities	51,437	2,139		53,576		53,576		53,576		11
12	Social Services	51,239			51,239		51,239		51,239		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Incontinent Supplies</b>										15
16	<b>TOTAL Health Care and Programs</b>	891,242	2,452		893,694		893,694		893,694		16
	<b>C. General Administration</b>										
17	Administrative	89,951	14,110	40,614	144,675		144,675	(14,186)	130,489		17
18	Directors Fees										18
19	Professional Services			28,328	28,328		28,328		28,328		19
20	Dues, Fees, Subscriptions & Promotions			(5)	(5)		(5)		(5)		20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			279,488	279,488		279,488		279,488		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,586	60,586	(21,663)	38,923		38,923		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	89,951	14,110	409,011	513,072	(21,663)	491,409	(14,186)	477,223		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,202,969	251,715	544,315	1,998,999	(21,663)	1,977,336	(16,439)	1,960,897		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name &amp; ID Number

Elizabeth Nursing Home

#0008300

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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	
	<b>D. Ownership</b>											
30	Depreciation			119,105	119,105	(70,380)	48,725	(3,611)	45,114			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,456	10,456		10,456	(9,833)	623			32
33	Real Estate Taxes			62,192	62,192	(37,315)	24,877		24,877			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			191,753	191,753	(107,695)	84,058	(13,444)	70,614			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			92,441	92,441		92,441		92,441			42
43	Other (specify):* <b>Assisted Living</b>	262,967	2,282	44,453	309,702	129,358	439,060		439,060			43
44	<b>TOTAL Special Cost Centers</b>	262,967	2,282	136,894	402,143	129,358	531,501		531,501			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,465,936	253,997	872,962	2,592,895		2,592,895	(29,883)	2,563,012			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(2,253)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(9,833)	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	(546)	17		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				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	(17,251)	PG5A		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (29,883)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (29,883)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Clinic Building Depreciation	\$ (3,611)	30	1
2	Marketing and Promotions	(13,440)	17	2
3	Vending Machine Revenue/Activity	(180)	17	3
4	Miscellaneous Income	(20)	17	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	<b>Total</b>	(17,251)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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	(2,253)	0	0	0	0	0	0	0	0	0	0	(2,253)	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	<b>TOTAL General Services</b>	<b>(2,253)</b>	<b>0</b>	<b>(2,253)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(14,186)	0	0	0	0	0	0	0	0	0	0	(14,186)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Administration</b>	<b>(14,186)</b>	<b>0</b>	<b>(14,186)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(16,439)</b>	<b>0</b>	<b>(16,439)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(3,611)	0	0	0	0	0	0	0	0	0	0	(3,611) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(9,833)	0	0	0	0	0	0	0	0	0	0	(9,833) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 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	<b>TOTAL Ownership</b>	<b>(13,444)</b>	<b>0</b>	<b>(13,444) 37</b>									
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(29,883)</b>	<b>0</b>	<b>(29,883) 45</b>									

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/16

Ending:

12/31/16

**VII. RELATED PARTIES**

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/16 Ending: 12/31/16

## 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	Megan Kaiser	Administrator	Administrator	0.00		40	100.00	Compensation	\$ 36,988	17	1
2	Dani Smallwood	Administrator	Administrator	0.00		40	100.00	Compensation	12,329	17	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,317		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/16

Ending: 12/31/16

**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	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/16 Ending: 12/31/16

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Mid-continent - capital lease		X	Digital TV System	\$329.00	9/30/16	\$ 17,224	\$ 16,471	9/30/21	5.5000	\$ 754	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Apple River State Bank - LOC		X	Line of Credit	Various	11/17/16	47,658	63,003	11/6/17	5.5000	417	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$329.00		\$ 64,882	\$ 79,474			\$ 1,171	9								
<b>B. Non-Facility Related*</b>																				
10	Shareholder Loans	X		Assisted Living Facility	Various	Various	1,438,979	1,296,989	Various	5.5000	36,269	10								
11	Shareholder Loans	X		Operations	Various	Various	820,000	300,000	Various	4.0000	7,983	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$ 2,258,979	\$ 1,596,989			\$ 44,252	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,323,861	\$ 1,676,463			\$ 45,423	15								

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

\*\* 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 2015 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 2016 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	2011	54,231	8
	2012	56,300	9
	2013	58,025	10
	2014	64,538	11
	2015	62,192	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2015 \$	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.**

SEE ACCOUNTANTS' PREPARATION REPORT

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Elizabeth Nursing Home COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 0008300

CONTACT PERSON REGARDING THIS REPORT Tracey Long

TELEPHONE (815) 858-2275 FAX #: (815) 858-2596

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-002-348-06</u>	<u>S25 T27 R2E PT NE NE</u>	\$ <u>62,192.00</u>	\$ <u>24,877.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>62,192.00</u></u>	\$ <u><u>24,877.00</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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 Elizabeth Nursing Home

# 0008300 Report Period Beginning:

01/01/16 Ending:

12/31/16

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 39,294 B. General Construction Type: Exterior Masonry / Siding Frame Masonry / 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).

Rented Clinic Area (attached to the Nursing Homes) - 1,400 sq. feet

Assisted Living Facility (attached to the Nursing Home complex) - 22,648 sq. feet

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			1967	\$ 5,275	1
2					2
3	TOTALS			\$ 5,275	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**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	41		1985	1985	\$ 151,186	\$	19	\$	\$	\$ 151,186	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Retiling Floor	1986		754		19			754	9
10		Door and Wall Guards	1986		1,063		19			1,063	10
11		B-Label Fire Door	1987		481	15	31.06	15		456	11
12		Rooftop Heat/Cool unit	1987		4,992	158	31.06	158		4,649	12
13		Service Entrance Exit Door	1988		810	26	31.06	26		733	13
14		Windows	1988		12,528	398	31.06	398		11,335	14
15		Retiling Floors	1989		977	31	31.06	31		856	15
16		Vinyl Siding	1989		1,056	34	31.06	34		911	16
17		Front Entrance / Exit Door	1989		860	27	31.06	27		740	17
18		Rooftop Heat/Cool unit	1989		5,555	176	31.06	176		4,776	18
19		Reroof East, North, & West	1990		49,329	1,566	31.06	1,566		40,847	19
20		Roof (East & West)	1992		8,194	260	31.06	260		6,373	20
21		Remodel Computer Office	1992		5,872	186	31.06	186		4,567	21
22		Center Structure Roof	1996		7,950	204	39	204		4,111	22
23		26 Toilets	1997		8,443		7			8,443	23
24		S/Wing AC & Heater Unit	1997		4,160		7			4,160	24
25		Kitchen Remodel	1997		22,802	577	39.06	577		11,257	25
26		Exterior Remodel	1997		20,031	507	39.06	507		9,889	26
27		NH Hand Rail	1998		8,483	215	39.06	215		3,973	27
28		Cast Iron Tub	1998		1,482	38	39.06	38		694	28
29		NH Additions	1998		97,742	2,474	39.06	2,474		45,778	29
30		Screen Door System	1999		425	11	39.06	11		188	30
31		140k Heating / Air Conditioning	2000		3,824	98	39	98		1,618	31
32		Energy Efficient Lighting	2000		12,431	319	39	319		5,259	32
33		Outside Lighting	2000		1,190	31	39	31		503	33
34		Koehler Utility Sink	2002		667		7			667	34
35		Tile Project - Dining Room	2003		2,113	67	31.06	67		900	35
36		AO Smith Holding Tank	2004		1,324		7			1,324	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**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	Flooring Nurses Station	2004	\$ 2,322	\$ 74	31.06	\$ 74		\$ 885	37
38	Ceiling Lights - NH	2004	484	15	31.06	15		184	38
39	Suspended Ceiling - Hallway	2004	4,765	151	31.06	151		1,815	39
40	Carpet / Flooring	2005	1,972	63	31.06	63		741	40
41	Sign	2005	551		7			551	41
42	Kitchen Fire Supression System	2005	1,200	38	31.06	38		435	42
43	Door Security System	2006	11,934	306	39	306		3,213	43
44	Shelves / Cabinets - Activity Room	2006	4,020		7			4,020	44
45	Garbage Shed	2006	1,437	37	39	37		387	45
46	Fire System	2006	20,553	527	39	527		5,534	46
47	Carbon Monoxide Detectors	2007	570	57	10	57		565	47
48	Boilers	2007	24,648	632	39	632		6,662	48
49	Garbage Disposal	2007	1,001		5			1,001	49
50	Sewer Line	2007	32,350	1,617	20	1,617		14,962	50
51	Flooring-Halls	2007	793	40	20	40		367	51
52	Dumpster	2007	1,169	117	10	117		1,062	52
53	Vinyl Flooring & Installation	2007	472	47	10	47		424	53
54	Kitchen Sewer Replacement	2008	6,568	328	20	328		2,928	54
55	Rooftop Airconditioners	2008	11,851	1,185	10	1,185		9,975	55
56	Corridor Door	2008	1,262	126	10	126		1,051	56
57	Exit Lights	2009	2,834	283	10	283		2,079	57
58	Roof Repair Gazebo	2011	580	58	10	58		305	58
59	Roof Repair	2012	13,267	1,327	10	1,327		6,302	59
60	Roof	2012	15,540	1,554	10	1,554		6,993	60
61	Spray Fire Protection	2012	13,792	1,379	10	1,379		6,206	61
62	Upstairs Remodel	2012	23,788	1,189	20	1,189		5,253	62
63	Electrical	2012	2,199	147	15	147		635	63
64	Sprinkler System	2013	59,458	3,964	15	3,964		13,874	64
65	Roof over Entry	2013	404	40	10	40		141	65
66	Bathroom Repairs	2013	3,691	246	15	246		861	66
67	Remodel - Painting	2014	1,475	295	5	295		738	67
68	Carpet	2014	2,259	452	5	452		1,130	68
69	Heating & Cooling Unit	2016	3,132	157	10	157		157	69
70	TOTAL (lines 4 thru 69)		\$ 709,065	\$ 23,869		\$ 23,869	\$	\$ 429,446	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

## 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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 709,065	\$ 23,869		\$ 23,869	\$	\$ 429,446	1
2	Water Heater	2016	4,409	147	10	147		147	2
3	Leasehold Improvements prior to 1981		119,177		10			119,177	3
4	3 Comm Smoke Detectors	1982	603		15			603	4
5	Air Conditioner	1982	931		15			931	5
6	Roof - South Wing	1983	10,500		15			10,500	6
7	8 - Triple Pane Windows	1984	5,131		18			5,131	7
8	15 Triple Pane Windows	1985	9,124		18			9,124	8
9	Thermiser Vent Control System	1985	2,927		19			2,927	9
10	Office Vision Panels	1985	910		19			910	10
11	2 Doors	2008	808	81	10	81		680	11
12									12
13	Land Improvements prior to 1981		939		10			939	13
14	Landscaping, tiling, sidewalk	1996	3,143		19			3,143	14
15	Landscaping - shrubs & gravel	1988	850		15			850	15
16	Sidewalks & Landscaping	1990	1,845		15			1,845	16
17	Seal Coat Parking Lot	1990	3,500		15			3,500	17
18	Landscaping	1998	995		15			995	18
19	Tile Work	1998	1,263		15			1,263	19
20	Landscaping	1999	1,185		15			1,185	20
21	Pavement Work	2001	1,840	72	15	72		1,840	21
22	Tree	2001	450	18	15	18		450	22
23	Shrubs and Landscaping Rock	2006	618	41	15	41		618	23
24	Parking Lot	2006	64,828	4,322	15	4,322		45,380	24
25									25
26	Admin offices in assisted living building (allocation)	1998		1,582	39	1,582		3,164	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 945,041	\$ 30,132		\$ 30,132	\$	\$ 644,748	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	\$ 102,634	\$ 13,728	\$ 13,728	\$		\$ 71,474	71
72	Current Year Purchases	20,223	1,248	1,248			1,248	72
73	Fully Depreciated Assets	398,714					398,714	73
74								74
75	TOTALS	\$ 521,571	\$ 14,976	\$ 14,976	\$		\$ 471,436	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,471,887	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,108	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,108	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)	\$ 1,116,184	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	Building Imp - Assisted Living	\$ 2,749,543	\$ 68,524	\$ 958,321	86
87	Building - Clinic	140,816	3,611	36,709	87
88	Land Imp - Assisted Living	8,212	59	7,948	88
89	Equipment - Assisted Living	63,587	1,803	61,985	89
90					90
91	TOTALS	\$ 2,962,158	\$ 73,997	\$ 1,064,963	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/16

Ending: 12/31/16

**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	<b>TOTAL</b>				\$			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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	<b>TOTAL</b>		\$	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

**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>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' PREPARATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					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		hrs							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			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 17,120	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,000</u> )	242,468		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,023		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 266,611	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	3,747,186		14
15	Leasehold Improvements, at Historical Cost	87,489		15
16	Equipment, at Historical Cost	585,158		16
17	Accumulated Depreciation (book methods)	(2,181,147)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Gift Fund</u> )			22
23	Other(specify): <u>Deferred Tax Asset</u>	191,300		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,435,261	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,701,872	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 89,231	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,000		28
29	Short-Term Notes Payable	451,162		29
30	Accrued Salaries Payable	107,145		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,000		32
33	Accrued Interest Payable	12,777		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Provider Assessment Fees</u>	36,347		36
37	<u>Deferred revenue</u>	2,950		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 782,612	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,227,301		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,227,301	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,009,913	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 691,959	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,701,872	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>764,862</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>764,862</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(72,903)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (72,903)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>691,959</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/16

Ending: 12/31/16

**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,500,382	1
2	Discounts and Allowances for all Levels	(9,488)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,490,894	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,253	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	180	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,433	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	511	24
25	Interest and Other Investment Income***	18	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 529	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Clinic Rent</u>	18,616	28
28a	<u>Miscellaneous</u>	20	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 18,636	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,512,492	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	592,233	31
32	Health Care	893,694	32
33	General Administration	513,072	33
<b>B. Capital Expense</b>			
34	Ownership	191,753	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	92,441	36
<b>D. Other Expenses (specify):</b>			
37	<u>Assisted Living</u>	309,702	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,592,895	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(80,403)	41
42	<b>Income Taxes</b>	7,500	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (72,903)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 688,522	44
45	Private Pay - Net Inpatient Revenue	1,811,860	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,500,382	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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	2,415	2,908	\$ 54,379	\$ 18.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,699	12,865	304,573	23.67	3
4	Licensed Practical Nurses	2,415	2,908	59,028	20.30	4
5	CNAs & Orderlies	32,032	35,015	373,250	10.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,485	1,527	51,611	33.80	10
11	Social Service Workers	3,350	3,611	51,442	14.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,036	13,143	138,849	10.56	15
16	Dishwashers					16
17	Maintenance Workers	2,954	3,458	23,603	6.83	17
18	Housekeepers	3,620	3,834	36,508	9.52	18
19	Laundry	2,319	2,507	23,565	9.40	19
20	Administrator	2,144	2,272	44,470	19.57	20
21	Assistant Administrator					21
22	Other Administrative	2,824	3,059	40,832	13.35	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 Care(specify)					32
33	Other(specify) <u>Other - Assisted Living</u>	16,859	18,445	263,855	14.30	33
34	TOTAL (lines 1 - 33)	96,152	105,552	\$ 1,465,965 *	\$ 13.89	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	51	\$ 2,259	1, 2	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	17	255	10, 2	38
39	Pharmacist Consultant	37	1,095	17, 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	6	335	11, 2	44
45	Social Service Consultant	6	335	17, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	117	\$ 4,279		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	
Megan Kaiser	Administrator	0	\$ 36,988	Workers' Compensation Insurance	\$ 26,918	IDPH License Fee	\$	
Dani Smallwood	Administrator	0	12,329	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	120,761	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	130,080	Patient Background Checks		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				Other miscellaneous benefits	1,729			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,317					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
			\$			Yellow page advertising	( )	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 279,488	TOTAL (agree to Sch. V, line 20, col. 8)	\$	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
			\$			\$		
			\$			\$	In-State Travel	
			\$			\$		
			\$			\$	Seminar Expense	
			\$			\$		
			\$			\$	Entertainment Expense	( )
			\$			\$		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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. IHCA Dues of \$300
- (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? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 92,441  
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? N/A
- (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? Yes 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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,253
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
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: Wipfli, 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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees

**SEE ACCOUNTANTS' PREPARATION REPORT**