



Facility Name & ID Number Autumn Meadows of Cahokia

# 0039636 Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	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	2,147	9	1,570	3,726	8
9	SNF/PED					9
10	ICF	19,102	6,038	723	25,863	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,249	6,047	2,293	29,589	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.04%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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  Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 7/1/1994

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 7/1/1994 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 30 and days of care provided 693

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Autumn Meadows of Cahokia # 0039636 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	223,432	21,647	5,404	250,483		250,483	-	250,483		1
2	Food Purchase		191,816		191,816		191,816	(20,360)	171,456		2
3	Housekeeping	159,884	32,834	-	192,718		192,718	96	192,814		3
4	Laundry	81,944	10,961	-	92,905	-	92,905	-	92,905		4
5	Heat and Other Utilities			132,337	132,337		132,337	997	133,334		5
6	Maintenance	58,784	70,605	21,406	150,795		150,795	1,633	152,428		6
7	Other (specify):*	-	-	-	-		-	-	-		7
8	<b>TOTAL General Services</b>	<b>524,044</b>	<b>327,863</b>	<b>159,147</b>	<b>1,011,054</b>	<b>-</b>	<b>1,011,054</b>	<b>(17,634)</b>	<b>993,420</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	-	-	12,000	12,000		12,000	-	12,000		9
10	Nursing and Medical Records	1,776,801	69,075	5,102	1,850,978		1,850,978	28,685	1,879,663		10
10a	Therapy	66,699	-	-	66,699		66,699	-	66,699		10a
11	Activities	75,045	8,513	-	83,558		83,558	-	83,558		11
12	Social Services	63,562	-	-	63,562		63,562	-	63,562		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):*	-	-	-	-		-	-	-		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,982,107</b>	<b>77,588</b>	<b>17,102</b>	<b>2,076,797</b>	<b>-</b>	<b>2,076,797</b>	<b>28,685</b>	<b>2,105,482</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	90,247	-	9,868	100,115		100,115	7,716	107,831		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			102,099	102,099		102,099	(49,325)	52,774		19
20	Dues, Fees, Subscriptions & Promotions			26,606	26,606		26,606	(4,177)	22,429		20
21	Clerical & General Office Expenses	563,958	-	81,927	645,885		645,885	51,820	697,705		21
22	Employee Benefits & Payroll Taxes			386,108	386,108		386,108	20,387	406,495		22
23	Inservice Training & Education			-	-		-	-	-		23
24	Travel and Seminar			1,975	1,975		1,975	277	2,252		24
25	Other Admin. Staff Transportation		-	2,911	2,911		2,911	916	3,827		25
26	Insurance-Prop.Liab.Malpractice			150,799	150,799		150,799	18,150	168,949		26
27	Other (specify):* <b>Mgmt Alloc Benefits</b>	-	-	-	-		-	16,016	16,016		27
28	<b>TOTAL General Administration</b>	<b>654,205</b>	<b>-</b>	<b>762,293</b>	<b>1,416,498</b>	<b>-</b>	<b>1,416,498</b>	<b>61,780</b>	<b>1,478,278</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,160,356</b>	<b>405,451</b>	<b>938,542</b>	<b>4,504,349</b>	<b>-</b>	<b>4,504,349</b>	<b>72,831</b>	<b>4,577,180</b>		<b>29</b>

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			54,187	54,187		54,187	117,766	171,953		30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-		31
32	Interest			49,737	49,737		49,737	116,831	166,568		32
33	Real Estate Taxes			3,788	3,788		3,788	138,969	142,757		33
34	Rent-Facility & Grounds			432,000	432,000		432,000	(432,000)	-		34
35	Rent-Equipment & Vehicles			8,442	8,442		8,442	949	9,391		35
36	Other (specify):* Mortgage Insurance			-	-		-	17,857	17,857		36
37	<b>TOTAL Ownership</b>			548,154	548,154	-	548,154	(39,628)	508,526		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation	-	-	-	-		-	-	-		38
39	Ancillary Service Centers	-	44,587	755,560	800,147		800,147	-	800,147		39
40	Barber and Beauty Shops	-	-	-	-		-	-	-		40
41	Coffee and Gift Shops	-	-	-	-		-	-	-		41
42	Provider Participation Fee			249,918	249,918		249,918	-	249,918		42
43	Other (specify):* Non-Allowable Cos	-	-	29,770	29,770		29,770	(29,770)	-		43
44	<b>TOTAL Special Cost Centers</b>	-	44,587	1,035,248	1,079,835	-	1,079,835	(29,770)	1,050,065		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,160,356	450,038	2,521,944	6,132,338	-	6,132,338	3,433	6,135,771		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident 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	(24,208)	30		9
10	Interest and Other Investment Income	(33,958)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(282)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,250)	43		18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(52,202)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,095)	43		24
25	Fund Raising, Advertising and Promotional	(3,003)	43		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 Page 5A	(23,871)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (150,269)		\$	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)	153,702		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 153,702		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 3,433		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

Autumn Meadows of Cahokia

ID# 0039636

Report Period Beginning: 1/1/17

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lab Expense Med A	\$ (6,923)	43	1
2	X Ray Expense Med A	(3,154)	43	2
3	Managed Care Cost	(5,690)	43	3
4	Disallow lobbying expense	(5,346)	20	4
5	Offset miscellaneous income	(996)	21	5
6	State Replacement Tax	2,027	43	6
7	Real Estate Tax	(3,789)	33	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(23,871)		49

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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	19 Professional Services	\$	Cahokia Building LLC	100%	\$ 7,780	\$ 7,780	1
2	V	20 Licenses & Dues		Cahokia Building LLC	100%	250	250	2
3	V	26 Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100%	16,976	16,976	3
4	V	30 Depreciation		Cahokia Building LLC	100%	138,969	138,969	4
5	V	32 Interest Income	133	Cahokia Building LLC	100%		(133)	5
6	V	32 Interest		Cahokia Building LLC	100%	149,425	149,425	6
7	V	32 Amortization		Cahokia Building LLC	100%	1,497	1,497	7
8	V	33 Real Estate Tax		Cahokia Building LLC	100%	133,752	133,752	8
9	V	34 Rent	432,000	Cahokia Building LLC	100%		(432,000)	9
10	V	36 Mortgage Insurance		Cahokia Building LLC	100%	17,857	17,857	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 432,133			\$ 466,506	\$ * 34,373	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Financial Services Company	100.00%	\$ 27	\$	27	15
16	V	3 Housekeeping		SW Financial Services Company	100.00%	96		96	16
17	V	5 Utilities		SW Financial Services Company	100.00%	997		997	17
18	V	6 Maintenance		SW Financial Services Company	100.00%	1,633		1,633	18
19	V	17 Administrative	9,868	SW Financial Services Company	100.00%	17,584		7,716	19
20	V	19 Professional Services		SW Financial Services Company	100.00%	1,016		1,016	20
21	V	20 Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	919		919	21
22	V	21 Clerical & General Office Expenses		SW Financial Services Company	100.00%	81,501		81,501	22
23	V	24 Travel & Seminar		SW Financial Services Company	100.00%	277		277	23
24	V	25 Other Admin. Staff Transportation		SW Financial Services Company	100.00%	916		916	24
25	V	26 Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	1,174		1,174	25
26	V	27 Management Allocated Benefits		SW Financial Services Company	100.00%	16,016		16,016	26
27	V	30 Depreciation		SW Financial Services Company	100.00%	3,005		3,005	27
28	V	33 Real Estate Taxes		SW Financial Services Company	100.00%	3,087		3,087	28
29	V	35 Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	949		949	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 9,868			\$ 129,197	\$ *	119,329	39

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

Facility Name &amp; ID Number

Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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	Abraham J Stern	4.67	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing Supp	Shabbona	Supportive Living	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Sheldon Wolfe	23.67			SW Financial	Skokie	Bookkeeping/	3
4	Ronnie Klein as Trustee	4.99			Services Co.		Management Comp	4
5	Maurice Aaron	4.67	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Michael Klein Revocable Trust	1.99	Oregon Living & Rehabilitation, LLC	Oregon				6
7	Wanda Bowling	0.67	Prairie Crossing Living & Rehab Center	Shabbona	Groves Community	Independence, MO	Hospice	7
8	Miriam Y Klein as Trustee	6.67	Maple Crossing at Amboy	Amboy	Hospice			8
9	Michael A Klein as Trustee	6.67			Forest View Senior	Independence, MO	Independent	9
10	Kenneth Klein	4.99	Tower Hill Rehabilitation LLC	South Elgin	Residences		Living	10
11	Susat Stern	4.67			White Oak Living	Independence, MO	Residential	11
12	Jonathan B Stern 2001 Trust	1.56	Beauvais Manor Healthcare and Rehab	St. Louis, MO	Center		Care	12
13	Todd A. Stern 2001 Trust	1.56	Hillside Manor Healthcare and Rehab	St. Louis, MO				13
14	Evan M. Stern	1.56	Rancho Manor Healthcare and Rehab	Florissant, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15	Moshe Herman	0.67	Rosewood Health & Rehab	Independence, MO	Program LLC			15
16	Ora Aaron	4.67	Seasons Care Center	Kansas City, MO				16
17			Carriage Square Living & Rehab	St. Joseph, MO	Cahokia Building LLC	Cahokia	Real Estae	17
18			Linn Living & Rehabilitation Center	Linn, MO	Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres Property	Amboy	Real Estate	19
20					LLC			20
21								21
22					FOM Property LLC	Franklin Grove	Real Estate	22
23								23
24					Oregon Property LLC	Oregon	Real Estate	24
25					Prairie Crossing	Shabbona	Real Estate	25
26					Property LLC			26
27								27
28					Tower Hill Property L	South Elgin	Real Estate	28
29		0						29
30		0						30

Facility Name & ID Number

Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending:

12/31/17

**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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	15
16								16
17					Carriage Square Prop	St. Joseph, MO	Real Estate	17
18								18
19					Linn Property LLC	Linn, MO	Real Estate	19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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## 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	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	4	8.89	Salary	\$ 3,822	L17, C7	1
2											2
3											3
4											4
5											5
6			Note: Mr. Wolfe works in excess of 40 hours per week.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,822		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 Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending: 12/31/17

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 SW Financial Services Co.  
 Street Address 7434 N. Skokie Blvd  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

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	2	Food	Bed Days Available	736,091	14	\$ 368	\$ 54,750	\$ 27	1	
2	3	Housekeeping	Bed Days Available	736,091	14	1,294	54,750	96	2	
3	5	Utilities	Bed Days Available	736,091	14	13,401	54,750	997	3	
4	6	Maintenance	Bed Days Available	736,091	14	21,957	54,750	1,633	4	
5	19	Professional Services-Legal	Bed Days Available	736,091	14	314	54,750	23	5	
6	19	Professional Services-Other	Bed Days Available	736,091	14	13,344	54,750	993	6	
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	736,091	14	12,352	54,750	919	7	
8	21	Clerical & General Office Expense	Bed Days Available	736,091	14	904,631	904,631	54,750	67,286	8
9	21	Clerical & General Office Expense	Bed Days Available	736,091	14	191,115	54,750	14,215	9	
10	24	Travel & Seminar	Bed Days Available	736,091	14	3,725	54,750	277	10	
11	25	Other Admin. Staff Transportation	Bed Days Available	736,091	14	12,311	54,750	916	11	
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	736,091	14	15,785	54,750	1,174	12	
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	736,091	14	215,324	54,750	16,016	13	
14	33	Real Estate Taxes	Bed Days Available	736,091	14	41,499	54,750	3,087	14	
15	35	Rent - Equipment & Vehicles	Bed Days Available	736,091	14	12,753	54,750	949	15	
16									16	
17	17	Administrative - Salary	Avg Hours Worked	45	14	154,818	154,818	4	13,762	17
18	17	Administrative - Salary	Avg Hours Worked	45	14	43,000	43,000	4	3,822	18
19									19	
20									20	
21	30	Depreciation	Direct Cost	40,403					3,005	21
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,657,991	\$ 1,102,449	\$ 129,197	25	

Facility Name & ID Number Autumn Meadows of Cahokia # 0039636 Report Period Beginning: 1/1/17 Ending: 12/31/17

**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	Heartland Bank		X	Mortgage	\$23,524.00	11/27/2001	\$ 3,961,000	\$ 3,551,525	12/1/2036	0.0635	\$ 149,425	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit	Interest Only	4/16/2017	1,000,000	496,369	5/15/2018	0.0475	49,737	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$23,524.00		\$ 4,961,000	\$ 4,047,894			\$ 199,162	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11											Amortization of Mortgage Costs	1,497	11							
12											Interest Income	(34,091)	12							
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (32,594)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 4,961,000	\$ 4,047,894			\$ 166,568	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 17,857 Line # 36

\* 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 2016 report.			\$	<b>148,900</b>	<b>1</b>
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.)		2016	\$	<b>137,651</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(11,249)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>145,000</b>	<b>4</b>
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>			\$	<b>5,919</b>	<b>5</b>
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>			\$	<b>3,087</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>142,757</b>	<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	<b>102,970</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2013	<b>130,106</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016 \$
	2014	<b>140,494</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	2015	<b>144,583</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$
	2016	<b>137,651</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>Tax Accrual = 137,651 * 1.05% = 144,534. Use \$145,000</b>					

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

## 2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Autumn Meadows of Cahokia COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039636

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(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>06-02.0-310-055</u>	<u>Long Term Care Property</u>	\$ <u>134,825.74</u>	\$ <u>134,825.74</u>
2. <u>06-02.0-310-054</u>	<u>Long Term Care Property</u>	\$ <u>2,825.30</u>	\$ <u>2,825.30</u>
3. <u>10-28-412-049-0000</u>	<u>SW Financial Services Co. Allocation</u>	\$ <u>39,550.72</u>	\$ <u>3,087.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>177,201.76</u></u>	\$ <u><u>140,738.04</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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 Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Resident Care, Office Space for Resident Care Em, and TOTALS.

Facility Name &amp; ID Number Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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		
	Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		2001		\$ 2,928,441	\$ -	15-40	\$ 68,691	\$ 68,691	\$ 1,197,085	4
5			2006		55,818	2,030	40	1,431	(599)	16,458	5
6						-		-			6
7						-		-			7
8		Allocated from Management Co.	1995		32,065	-		916	916	20,755	8
		Improvement Type**									
9	Various		1994		17,859	268	20		(268)	17,859	9
10	Various		1995		33,623	271	20		(271)	33,623	10
11	Various		1996		2,178	56	20		(56)	2,178	11
12	Various		1997		9,423		20	233	233	9,423	12
13	Various		1998		4,800		20	240	240	4,680	13
14	Various		1999		16,266	93	20	813	720	15,229	14
15	Air Handler		2000		1,516		5			1,516	15
16	Alarm System		2001		1,908		5			1,908	16
17	Blind		2001		1,212		5			1,212	17
18	Air Handler		2001		1,317		20	66	66	1,088	18
19	Fan Motor		2001		1,123		20	56	56	902	19
20	Drywall-Dining Room		2002		10,650	184	10		(184)	10,650	20
21	Door		2002		9,860	184	20	493	309	7,436	21
22	Air Conditioner		2002		1,198		7			1,198	22
23	Air Conditioner		2002		1,582		7			1,582	23
24	Air Conditioners		2002		4,284		7			4,284	24
25	Compressor Air Maxi		2002		1,269		7			1,269	25
26	Roof - New		2003		97,996		20	4,900	4,900	72,274	26
27	Nursing Station		2003		35,060		20	1,753	1,753	25,126	27
28	Nursing Station		2003		28,692		20	1,435	1,435	21,761	28
29	Nursing Station		2003		6,368		20	318	318	4,482	29
30	Replace Accelerator		2003		968		20	48	48	723	30
31	Sprinkler System		2004		3,610	131	20	181	50	2,440	31
32	Smoke shelter		2004		6,041	220	20	302	82	4,077	32
33	Security System		2005		11,166	406	20	558	152	6,976	33
34	Condensing Unit - 5 Ton		2005		1,959		20	98	98	1,225	34
35	Cabinets and countertops		2005		110,923	4,011	20	5,546	1,535	69,326	35
36	Air Handler		2005		1,549		20	78		972	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending:

12/31/17

## XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Asphalt Parking Lot	2005	\$ 5,570	\$ 329	20	\$ 279	\$ (51)	\$ 3,483	37
38 A/C Unit 2 Tons	2005	1,092	40	20	55	15	683	38
39 Reframe & drywall 3 windows	2005	4,200	153	20	210	57	2,625	39
40 Carpet & Vinyl Floor	2005	4,390		20	220	220	2,745	40
41 Sprinkler System - new pipe	2005	1,463		20	73	73	914	41
42 Door Alarms	2005	3,587	130	20	179	49	2,240	42
43 Wallpaper	2005	17,835		20	892	892	11,148	43
44 Painting and Wallcovering	2005	29,600		20	1,480	1,480	18,500	44
45 6 Doors	2005	1,926		20	96	96	1,203	45
46 Plaster Ceiling	2005	10,392	378	20	520	142	6,496	46
47 Vinyl Flooring	2005	4,878	177	20	244	67	3,049	47
48 Duct Heater	2006	1,195		20	60	60	688	48
49 Kitchen Garbage Disposal	2006	1,467		20	73	73	842	49
50 Copper Pipe & Concrete	2006	3,722		20	186	186	2,139	50
51 Fence	2006	6,061	358	20	303	(55)	3,485	51
52 Shower Remodel - Hall 400	2006	21,570	784	20	1,079	295	12,404	52
53 Tile Kitchen Floor	2006	9,750	355	20	488	133	5,608	53
54 Shower Remodel - Hall 200	2006	21,570	784	20	1,079	295	12,404	54
55 Shower Remodel - Hall 500	2006	21,570	784	20	1,079	295	12,404	55
56 Sprinkler System - new pipe	2006	19,579	712	20	979	267	11,258	56
57 Front Entrance	2006	2,150	78	20	108	30	1,238	57
58 4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	1,932	58
59 3 Ton Condensing Unit	2006	1,729	63	20	86	23	993	59
60 Compressor-Walk In Freezer	2006	1,784		20	89	89	1,025	60
61 Air Conditioners (5)	2006	2,146		10			2,146	61
62 Air Conditioners (6)	2006	2,576		20	129	129	1,482	62
63 Phone System	2006	1,658		20	83	83	954	63
64 Remove & reinstall 6 dry pendants	2007	3,039	111	20	152	41	1,596	64
65 2 Hot Water Heaters	2007	7,500	273	20	375	102	3,938	65
66 2 Mixing valves for hot water heaters	2007	3,160	115	20	84	(32)	1,287	66
67 New Window Glass	2007	3,562		20	178	178	1,869	67
68 Paving, Parking Lot & Driveway	2007	32,275	1,773	20	1,614	(159)	10,940	68
69 Handrails	2007	2,980		20	149	149	1,565	69
70 TOTAL (lines 4 thru 69)		\$ 3,700,061	\$ 15,373		\$ 100,941	\$ 85,490	\$ 1,704,996	70

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

Facility Name &amp; ID Number Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

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## XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,700,061	\$ 15,373		\$ 100,941	\$ 85,568	\$ 1,704,996	1
2	2007	5114	103	20	256	153	2,686	2
3	2007	8790		20	440	440	4,616	3
4	2008	2316	84	20	116	32	1,216	4
5	2008	3158	115	20	158	43	1,501	5
6	2008	29310	1,066	20	1,466	400	13,924	6
7	2009	2685		20	134	134	1,275	7
8	2009	5182	185	20	259	74	2,202	8
9	2009	14512		20	726	726	6,171	9
10	2010	5094		20	255	255	2,167	10
11	2011	3310	120	20	166	46	1,242	11
12	2011	33231.61	1,208	20	1,662	454	10,801	12
13	2011	21394.21		20	1,070	1,070	6,954	13
14								14
15	2012	5847.5		20	455	455	2,501	15
16	2012	19098		20	637	637	3,501	16
17								17
18	2013	3213		20	161	161	723	18
19	2013	15085		20	754	754	3,394	19
20								20
21								21
22	2013	4380		20	219	219	986	22
23								23
24								24
25								25
26								26
27								27
28	2013	54724		20	2,736	2,736	12,313	28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,936,505	\$ 18,254		\$ 112,608	\$ 94,354	\$ 1,783,166	34

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

Facility Name &amp; ID Number Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending:

12/31/17

## XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,936,505	\$ 18,254		\$ 112,608	\$ 94,354	\$ 1,783,166	1
2	2013	30,088		20	1,504	1,504	6,770	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12	2013	17,758		20	888	888	3,996	12
13								13
14	2014	2,750	104	20	183	79	596	14
15	2014	17,831		20	892	892	3,566	15
16	2014	3,210	117	20	161	44	642	16
17	2014	4,727	172	20	236	64	945	17
18	2014	3,100		20	155	155	620	18
19	2014	2,647	96	20	132	36	529	19
20								20
21	2015	7,029		20	351	351	879	21
22	2015	3,000		20	150	150	375	22
23	2015	3,074		20	154	154	384	23
24	2015	2,686		20	134	134	336	24
25	2015	2,869		20	143	143	359	25
26								26
27	2016	12,882	612	20	859	247	1,181	27
28	2016	4,689	171	20	234	63	352	28
29	2016	7,775	283	20	389	106	583	29
30	2016	9,190	334	20	460	126	689	30
31	2016	4,154	151	20	208	57	312	31
32	2016	5,476	199	20	274	75	411	32
33								33
34		\$ 4,081,440	\$ 20,493		\$ 120,115	\$ 99,622	\$ 1,806,690	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 4,081,440	\$ 20,493		\$ 120,115	\$ 99,622	\$ 1,806,690	1
2	2016	7,307	266	20	365	99	548	2
3	2016	3,862	140	20	193	53	290	3
4	2016	6,000	218	20	300	82	450	4
5	2016	5,578	892	5	1,116	224	1,673	5
6	2016	3,819	611	5	764	153	1,146	6
7	2016	13,104		15	844	844	1,280	7
8								8
9	2017	257,398		40	3,217	3,217	3,217	9
10	2017	11,514	6,810	10	378	(6,432)	378	10
11	2017	2,557		20	64	64	64	11
12								12
13	2017	2,923	93	5	487	394	487	13
14	2017	2,723	54	10	159	105	159	14
15								15
16								16
17								17
18								18
19	1995	3,589		20			3,589	19
20	1996	597		20	2	2	597	20
21	1997	693		20			693	21
22	1998	592		20	30	30	585	22
23	1999	1,645		20	82	82	1,487	23
24	2005	3,402		20	170	170	2,127	24
25	2007	1,926		20	96	96	1,011	25
26	2009	4,021		20	201	201	1,709	26
27	2013	2,147		20	107	107	483	27
28	2014	2,165		20	108	108	379	28
29	2015	444		20	30	30	74	29
30								30
31								31
32								32
33								33
34		\$ 4,419,446	\$ 29,577		\$ 128,828	\$ 99,251	\$ 1,829,117	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 260,831	\$ 19,506	\$ 38,106	\$ 18,600	5-10	\$ 154,980	71
72	Current Year Purchases	4,811	2,887	515	(2,372)	5	515	72
73	Fully Depreciated Assets	241,808					241,808	73
74	Allocated from Mgmt Co	13,231		477	477		9,513	74
75	TOTALS	\$ 520,681	\$ 22,393	\$ 39,098	\$ 16,705		\$ 406,816	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	Facility Use	2014 Chrysler Town & Country	2014	\$ 32,408	\$ 2,217	\$ 3,241	\$ 1,024	5	\$ 16,204	76
77					-	-				77
78	Allocated from Mgmt Co	2017 Land Rover Evoque	2017	7,854	-	785	785	5	785	78
79					-	-				79
80	TOTALS			\$ 40,262	\$ 2,217	\$ 4,026	\$ 1,809		\$ 16,989	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)	\$ 5,225,389	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,187	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 171,953	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 117,766	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,252,922	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Autumn Meadows of Cahokia

# 0039636

Report Period Beginning: 1/1/17

Ending: 12/31/17

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	<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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</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: \$ 8,442 Description: Medical Equipment \$8,442

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Management Co.</u>		\$	<u>949</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	<b>949</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.

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		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	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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	\$	4,284	\$ 308,466	\$	4,284	\$ 308,466	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		3,370	161,775		3,370	161,775	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		4,458	285,319		4,458	285,319	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				42,180		42,180	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	L39, C2					2,407		2,407	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	12,112	\$ 755,560	\$ 44,587	12,112	\$ 800,147	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 Autumn Meadows of Cahokia

# 0039636

Report Period Beginning: 1/1/17

Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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	\$ 13,725	\$ 25,818	1
2	Cash-Patient Deposits	27,155	27,155	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 61,313 )	1,963,711	1,963,711	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,514	34,969	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	485,131	682,239	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,512,236	\$ 2,733,892	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	3,016,323	14
15	Leasehold Improvements, at Historical Cost	733,329	1,403,123	15
16	Equipment, at Historical Cost	461,453	560,943	16
17	Accumulated Depreciation (book methods)	(797,154)	(2,252,922)	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>Capitalized Costs</u> )		33,528	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 468,446	\$ 3,005,995	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,980,682	\$ 5,739,887	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 126,833	\$ 134,613	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,928	26,928	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	163,183	163,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,885	16,885	31
32	Accrued Real Estate Taxes(Sch.IX-B)		145,000	32
33	Accrued Interest Payable		11,779	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Schedule 17A	731,047	739,090	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,064,876	\$ 1,237,478	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	496,369	4,047,894	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>	\$ 496,369	\$ 4,047,894	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,561,245	\$ 5,285,372	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,419,437	\$ 454,515	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,980,682	\$ 5,739,887	48

\*(See instructions.)

**Facility Name:** Autumn Meadows of Cahokia  
**IDPH License ID Number:** 0039636  
**Fiscal Year End:** 12/31/17

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Current Assets Other (specify):**

Description	Operating	After Consolidation
1139 RE REPLACEMENT RESERVE	-	92,728
1201 RE ESCROW REAL ESTATE TAX	-	104,380
2073 DUE FROM STATE - INTEREST	47,989	47,989
3015 EMPLOYEE PAYROLL ADVANCE	87	87
3030 SHORT TERM LOAN EXCHANGE	(187,587)	(187,587)
3031 FIRE REIMBURSEMENT FROM CNA	624,642	624,642
<b>Total - Line 9</b>	<b>485,131</b>	<b>682,239</b>

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

Description	Operating	After Consolidation
2070 DUE FROM STATE	133,601	133,601
3029 REIMBURSEMENT DUE	(13,314)	(13,314)
7310 ACCRUED EXPENSES	334,078	334,078
8811 DUE/FROM CAHOKIA PROPERTY LLC	262,509	270,552
8815 DUE/FROM VACANT CAHOKIA PROP.	14,173	14,173
<b>Total - Line 36</b>	<b>731,047</b>	<b>739,090</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,326,336</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>609,996</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>1,936,332</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(516,895)</b>	<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>	\$ <b>(516,895)</b>	<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>1,419,437</b>	<b>24</b> *

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

Facility Name &amp; ID Number Autumn Meadows of Cahokia

# 0039636

Report Period Beginning: 1/1/17

Ending: 12/31/17

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,664,297	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,664,297	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	910,989	6
7	Oxygen	5,203	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 916,192	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	33,958	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 33,958	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	996	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 996	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,615,443	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,011,054	31
32	Health Care	2,076,797	32
33	General Administration	1,416,498	33
<b>B. Capital Expense</b>			
34	Ownership	548,154	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	829,917	35
36	Provider Participation Fee	249,918	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,132,338	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(516,895)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (516,895)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,836,690	44
45	Private Pay - Net Inpatient Revenue	159,489	45
46	Medicare - Net Inpatient Revenue	349,035	46
47	Other-(specify) <b>Hospice</b>	26,772	47
48	Other-(specify) <b>VA</b>	292,311	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,664,297	49

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

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

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

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

Facility Name & ID Number Autumn Meadows of Cahokia

# 0039636

Report Period Beginning:

1/1/17

Ending:

12/31/17

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	\$ 70,302	\$ 36.62	1
2	Assistant Director of Nursing	1,696	50,138	26.78	2
3	Registered Nurses	6,555	192,843	27.27	3
4	Licensed Practical Nurses	19,314	501,907	23.88	4
5	CNAs & Orderlies	67,156	961,611	12.93	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	3,591	66,699	16.66	8
9	Activity Director				9
10	Activity Assistants	4,841	75,045	14.23	10
11	Social Service Workers	3,834	63,562	15.87	11
12	Dietician				12
13	Food Service Supervisor	1,968	47,874	23.29	13
14	Head Cook	7,588	87,024	10.68	14
15	Cook Helpers/Assistants	6,615	88,534	12.06	15
16	Dishwashers				16
17	Maintenance Workers	3,660	58,784	15.30	17
18	Housekeepers	13,400	159,884	10.45	18
19	Laundry	7,527	81,944	10.24	19
20	Administrator	2,016	90,247	44.24	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	12,566	385,933	29.39	23
24	Clerical	6,740	178,025	24.16	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	170,987	\$ 3,160,356 *	\$ 16.92	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	Monthly \$ 5,404	L1, C3	35
36	Medical Director	Monthly 12,000	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 5,102	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,506		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Danielle Young	Administrator	0	\$ 90,247	Workers' Compensation Insurance	\$ 40,249	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	50,593	Advertising: Employee Recruitment		
				FICA Taxes	237,101	Health Care Worker Background Check		
				Employee Health Insurance	53,017	(Indicate # of checks performed 235 )	2,823	
				Employee Meals	20,387	Patient Background Checks	2,000	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Inspections & Licenses	1,879	
				Miscellaneous Employee Benefits	5,148	Miscellaneous Dues & Permits	1,714	
TOTAL (agree to Schedule V, line 17, col. 1)						Illinois Council on Long Term Care	16,200	
(List each licensed administrator separately.)			\$ 90,247			Allocated from R/E Entity	250	
<b>B. Administrative - Other</b>						Allocated from Management Co.	919	
Description			Amount			Less: Public Relations Expense	(5,346)	
SW Financial Services Co			\$ 9,868			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 9,868	TOTAL (agree to Schedule V, line 22, col.8)	\$ 406,495	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,429	
(Attach a copy of any management service agreement)				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount	N/A		\$	Out-of-State Travel	\$
RSM US LLP	Accounting		\$ 28,272					
Unemployment Consultants	U/E consultant		1,900					
HelperBroom LLC	Legal		2,507					
Allen Lefkovitz & Associates	Legal		5,919				In-State Travel	
Polsinelli	Legal		52,396					
Brown & Rupert PC	Legal		510					
MB Financial	Legal		595					
Nadia Consulting LLC	Administrative Consultant		10,000				Seminar Expense	1,975
							Allocated from Home Office	277
TOTAL (agree to Schedule V, line 19, column 3)			\$ 102,099	TOTAL		\$	Entertainment Expense	( )
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,252

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Autumn Meadows of Cahokia  
**IDPH License ID Number:** 0039636  
**Fiscal Year End:** 12/31/17

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Professional Fees from Page 20 Section C		102,099

**Total (agree to Schedule V, line 19, column 3)** 102,099

Allocated from Management Company Legal Fees	23
Allocated from Management Company Professional Services	993
Allocated from Real Estate Entity Professional Services	7,780
Less: Non-Allowable Legal Fees	(52,202)
Less: Reclass to R/E Tax Expense	(5,919)

**Total (agree to Schedule V, line 19, column 8)** 52,774

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. Illinois Council on Long Term Care-\$16,200
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,516 Line 10
- (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  NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO  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. \$ 249,918  
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. \$ 20,387 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? Adequate records have been maintained
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
  - 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? No  
Firm Name: N/A
- (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