

Facility Name & ID Number Elizabeth Nursing Home

0008300 Report Period Beginning: 01/01/17 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

	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	14,965	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	14,965	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	1,096	8,064		9,160	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,096	8,064		9,160	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.21%

D. How many bed reserve days during this year were paid by the Department?
0 (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)

Assisted Living Facility, Rental of Clinic Space

F. Does the facility maintain a daily midnight census?

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

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/17 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
	A. General Services										
1	Dietary	129,318	527		129,845		129,845		129,845		1
2	Food Purchase		113,342		113,342		113,342	(1,362)	111,980		2
3	Housekeeping	23,644			23,644		23,644		23,644		3
4	Laundry	30,936			30,936		30,936		30,936		4
5	Heat and Other Utilities			90,511	90,511		90,511		90,511		5
6	Maintenance	45,706	33,526	24,405	103,637		103,637		103,637		6
7	Other (specify):*										7
8	TOTAL General Services	229,604	147,395	114,916	491,915		491,915	(1,362)	490,553		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	726,306	77,437		803,743		803,743		803,743		10
10a	Therapy										10a
11	Activities	35,142	3,800		38,942		38,942		38,942		11
12	Social Services	45,723			45,723		45,723		45,723		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	807,171	81,237		888,408		888,408		888,408		16
	C. General Administration										
17	Administrative	134,334	7,961	43,154	185,449		185,449	5,765	191,214		17
18	Directors Fees										18
19	Professional Services			44,957	44,957		44,957		44,957		19
20	Dues, Fees, Subscriptions & Promotions			5,977	5,977		5,977		5,977		20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			290,930	290,930		290,930		290,930		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,710	58,710	(20,992)	37,718		37,718		26
27	Other (specify):*										27
28	TOTAL General Administration	134,334	7,961	443,728	586,023	(20,992)	565,031	5,765	570,796		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,171,109	236,593	558,644	1,966,346	(20,992)	1,945,354	4,403	1,949,757		29

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

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

Facility Name & ID Number

Elizabeth Nursing Home

#0008300

Report Period Beginning:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			119,419	119,419	(69,523)	49,896	(3,611)	46,285			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,450	4,450		4,450	(4,185)	265			32
33	Real Estate Taxes			62,340	62,340	(37,404)	24,936		24,936			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			186,209	186,209	(106,927)	79,282	(7,796)	71,486			37
	Ancillary Expense											
	E. Special Cost Centers											
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			77,167	77,167		77,167		77,167			42
43	Other (specify):* Assisted Living	176,611		65,322	241,933	127,919	369,852		369,852			43
44	TOTAL Special Cost Centers	176,611		142,489	319,100	127,919	447,019		447,019			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,347,720	236,593	887,342	2,471,655		2,471,655	(3,393)	2,468,262			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	(1,362)	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	(4,185)	32		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	8,789	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	(6,635)	PG5A		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,393)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,393)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Clinic Building Depreciation	\$ (3,611)	30	1
2	Marketing and Promotions	(2,869)	17	2
3	Vending Machine Revenue/Activity	(155)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,635)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	(1,362)	0	0	0	0	0	0	0	0	0	0	(1,362)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,362)	0	(1,362)	8									
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	5,765	0	0	0	0	0	0	0	0	0	0	5,765	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	TOTAL General Administration	5,765	0	5,765	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	4,403	0	4,403	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(4,185)	0	0	0	0	0	0	0	0	0	0	(4,185) 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	TOTAL Ownership	(7,796)	0	(7,796) 37									
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,393)	0	(3,393) 45									

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.

Facility Name & ID Number

Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/17

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								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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Dani Smallwood	Administrator	Administrator	0.00		40	100.00	Compensation	\$ 35,964	17	1
2	Angela Horaney	Administrator	Administrator	0.00		40	100.00	Compensation	10,385	17	2
3	Tracey Long	Administrator	Administrator	0.00		40	100.00	Compensation	22,352	17	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 68,701		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 Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/17

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 _____

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/17 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			
A. Directly Facility Related																				
Long-Term																				
1	Mid-continent - capital lease		X	Digital TV System	\$329.00	9/30/16	\$ 17,224	\$ 13,350	9/30/21	5.5000	\$ 10,837	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Apple River State Bank - LOC		X	Line of Credit	Various	11/6/17	65,004	193,400	11/6/18	5.5000	828	6								
7												7								
8												8								
9	TOTAL Facility Related				\$329.00		\$ 82,228	\$ 206,750			\$ 11,665	9								
B. Non-Facility Related*																				
10	Shareholder Loans	X		Assisted Living Facility	Various	Various	1,438,979	1,108,000	Various	5.5000	27,557	10								
11	Shareholder Loans	X		Operations	Various	Various	820,000	359,181	Various	4.0000	10,093	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 2,258,979	\$ 1,467,181			\$ 37,650	14								
15	TOTALS (line 9+line14)						\$ 2,341,207	\$ 1,673,931			\$ 49,315	15								

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 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 2017 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u> 56,300</u>	8
	2013	<u> 58,025</u>	9
	2014	<u> 64,538</u>	10
	2015	<u> 62,192</u>	11
	2016	<u> 62,340</u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

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 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 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>07-002-348-06</u>	<u>S25 T27 R2E PT NE NE</u>	\$ <u>62,340.10</u>	\$ <u>24,936.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>62,340.10</u></u>	\$ <u><u>24,936.00</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 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 Elizabeth Nursing Home

0008300 Report Period Beginning:

01/01/17 Ending:

12/31/17

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? [X] (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? [X] (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 [X] NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: 1, Use, Square Feet, 1967, \$ 5,275, 1. Row 2: 2, Use, Square Feet, Year Acquired, Cost, 2. Row 3: 3, TOTALS, Square Feet, Year Acquired, \$ 5,275, 3.

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/17

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		
	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
	Improvement Type**										
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	31.5	15		471	11
12		Rooftop Heat/Cool unit	1987		4,992	158	31.5	158		4,807	12
13		Service Entrance Exit Door	1988		810	26	31.5	26		759	13
14		Windows	1988		12,528	398	31.5	398		11,733	14
15		Retiling Floors	1989		977	31	31.5	31		887	15
16		Vinyl Siding	1989		1,056	34	31.5	34		944	16
17		Front Entrance / Exit Door	1989		860	27	31.5	27		767	17
18		Rooftop Heat/Cool unit	1989		5,555	176	31.5	176		4,953	18
19		Reroof East, North, & West	1990		49,329	1,566	31.5	1,566		42,413	19
20		Roof (East & West)	1992		8,194	260	31.5	260		6,633	20
21		Remodel Computer Office	1992		5,872	186	31.5	186		4,753	21
22		Center Structure Roof	1996		7,950	204	39	204		4,315	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	39.5	577		11,834	25
26		Exterior Remodel	1997		20,031	507	39.5	507		10,396	26
27		NH Hand Rail	1998		8,483	215	39.5	215		4,188	27
28		Cast Iron Tub	1998		1,482	38	39.5	38		732	28
29		NH Additions	1998		97,742	2,474	39.5	2,474		48,252	29
30		Screen Door System	1999		425	11	39.5	11		199	30
31		140k Heating / Air Conditioning	2000		3,824	98	39	98		1,716	31
32		Energy Efficient Lighting	2000		12,431	319	39	319		5,578	32
33		Outside Lighting	2000		1,190	31	39	31		534	33
34		Koehler Utility Sink	2002		667		7			667	34
35		Tile Project - Dining Room	2003		2,113	67	31.5	67		967	35
36		Flooring Nurses Station	2004		2,322	74	31.5	74		958	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/17

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Suspended Ceiling - Hallway	2004	\$ 4,765	\$ 151	31.5	\$ 151	\$	\$ 1,967	37
38	Carpet / Flooring	2005	1,972	63	31.5	63		803	38
39	Sign	2005	551		7			551	39
40	Kitchen Fire Supression System	2005	1,200	38	31.5	38		473	40
41	Door Security System	2006	11,934	306	31.5	306		3,519	41
42	Shelves / Cabinets - Activity Room	2006	4,020		7			4,020	42
43	Garbage Shed	2006	1,437	37	39	37		424	43
44	Fire System	2006	20,553	527	39	527		6,061	44
45	Carbon Monoxide Detectors	2007	570	5	10	5		570	45
46	Boilers	2007	24,648	632	39	632		7,294	46
47	Sewer Line	2007	32,350	1,617	20	1,617		16,579	47
48	Flooring-Halls	2007	793	40	20	40		407	48
49	Dumpster	2007	1,169	107	10	107		1,169	49
50	Vinyl Flooring & Installation	2007	472	47	10	47		472	50
51	Kitchen Sewer Replacement	2008	6,568	328	20	328		3,257	51
52	Rooftop Airconditioners	2008	11,851	1,185	10	1,185		11,160	52
53	Corridor Door	2008	1,262	126	10	126		1,178	53
54	Exit Lights	2009	2,834	283	10	283		2,362	54
55	Roof Repair Gazebo	2011	580	58	10	58		363	55
56	Roof Repair	2012	13,267	1,327	10	1,327		7,629	56
57	Roof	2012	15,540	1,554	10	1,554		8,547	57
58	Spray Fire Protection	2012	13,792	1,379	10	1,379		7,586	58
59	Upstairs Remodel	2012	23,788	1,189	20	1,189		6,443	59
60	Electrical	2012	2,199	147	15	147		782	60
61	Sprinkler System	2013	59,458	3,964	15	3,964		17,837	61
62	Roof over Entry	2013	404	40	10	40		182	62
63	Bathroom Repairs	2013	3,691	246	15	246		1,107	63
64	Remodel - Painting	2014	1,475	295	5	295		1,033	64
65	Carpet	2014	2,259	452	5	452		1,581	65
66	Heating & Cooling Unit	2016	3,132	313	10	313		470	66
67	Water Heater	2016	4,409	441	10	441		588	67
68	Holding Tank for Hot Water	2017	4,464	372	10	372		372	68
69	Gaco Roof Coating on Area A	2017	19,956	499	10	499		499	69
70	TOTAL (lines 4 thru 69)		\$ 735,085	\$ 25,260		\$ 25,260	\$	\$ 452,347	70

**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:

01/01/17

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 735,085	\$ 25,260		\$ 25,260		\$ 452,347		1
2	Leasehold Improvements prior to 1986	142,008		10			142,008		2
3	Land Improvements prior to 1986	939		10			939		3
4	Landscaping, tiling, sidewalk	1986 3,143		19			3,134		4
5	Landscaping - shrubs & gravel	1988 850		15			850		5
6	Sidewalks & Landscaping	1990 1,845		15			1,845		6
7	Seal Coat Parking Lot	1990 3,500		15			3,500		7
8	Landscaping	1998 995		15			995		8
9	Tile Work	1998 1,263		15			1,263		9
10	Landscaping	1999 1,185		15			1,185		10
11	Pavement Work	2001 1,840		15			1,840		11
12	Tree	2001 450		15			450		12
13	Shrubs and Landscaping Rock	2006 618	41	15	41		474		13
14	Parking Lot	2006 64,828	4,322	15	4,322		49,702		14
15									15
16	Admin offices in assisted living building (allocation)	1998	1,568	39	1,568		3,132		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 958,549	\$ 31,191		\$ 31,191		\$ 663,664		34

**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:

01/01/17

Ending:

12/31/17

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	\$ 55,024	\$ 13,024	\$ 13,024	\$		\$ 17,913	71
72	Current Year Purchases	18,326	2,400	2,400			2,400	72
73	Fully Depreciated Assets	384,963					385,002	73
74								74
75	TOTALS	\$ 458,313	\$ 15,424	\$ 15,424	\$		\$ 405,315	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)	\$ 1,422,137	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,615	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,615	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)	\$ 1,068,979	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	\$ 2,741,166	\$ 70,400	\$ 1,031,504	86
87	Building - Clinic	140,816	3,611	40,319	87
88	Land Imp - Assisted Living	8,212	59	8,006	88
89	Equipment - Assisted Living	59,933	633	58,964	89
90					90
91	TOTALS	\$ 2,950,127	\$ 74,703	\$ 1,138,793	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.

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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	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		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.

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 11,262	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	275,421		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,084		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 308,767	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	3,619,494		14
15	Leasehold Improvements, at Historical Cost	87,489		15
16	Equipment, at Historical Cost	663,909		16
17	Accumulated Depreciation (book methods)	(2,209,177)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Tax Asset</u>	226,900		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,393,890	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,702,657	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 52,824	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,000		28
29	Short-Term Notes Payable	630,975		29
30	Accrued Salaries Payable	98,278		30
31	Accrued Taxes Payable (excluding real estate taxes)	62,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,273		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Provider Assessment Fees</u>	18,026		36
37	<u>Deferred revenue</u>	5,007		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 906,383	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,041,690		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,041,690	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,948,073	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 753,584	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,701,657	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 691,959	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 691,959	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,625	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 61,625	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 753,584	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/17

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,490,812	1
2	Discounts and Allowances for all Levels	(20,757)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,470,055	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,362	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	155	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,517	23
D. Non-Operating Revenue			
24	Contributions	7,166	24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,174	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Clinic Rent</u>	18,934	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,934	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,497,680	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	491,915	31
32	Health Care	888,408	32
33	General Administration	586,023	33
B. Capital Expense			
34	Ownership	186,209	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	77,167	36
D. Other Expenses (specify):			
37	<u>Assisted Living</u>	241,933	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,471,655	40
41	Income before Income Taxes (line 30 minus line 40)**	26,025	41
42	Income Taxes	35,600	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 61,625	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 323,898	44
45	Private Pay - Net Inpatient Revenue	2,147,580	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,471,478	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/17

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	895	1,008	\$ 25,970	\$ 25.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,480	11,524	298,989	25.94	3
4	Licensed Practical Nurses	2,132	2,567	54,356	21.17	4
5	CNAs & Orderlies	27,016	29,532	346,991	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,442	2,511	35,142	14.00	10
11	Social Service Workers	2,961	3,192	45,723	14.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,707	11,692	129,318	11.06	15
16	Dishwashers					16
17	Maintenance Workers	2,553	2,989	45,706	15.29	17
18	Housekeepers	2,216	2,347	23,644	10.07	18
19	Laundry	3,004	3,248	30,936	9.52	19
20	Administrator	2,697	2,858	68,925	24.12	20
21	Assistant Administrator					21
22	Other Administrative	4,181	4,529	65,409	14.44	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>	13,906	15,214	176,611	11.61	33
34	TOTAL (lines 1 - 33)	85,190	93,211	\$ 1,347,720 *	\$ 14.46	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

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? No
If YES, give association name and amount. _____
- (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. \$ 77,167
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. \$ 1,362
- (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