

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0025239 Facility Name: ROLLING HILLS MANOR Address: 3615 16TH STREET ZION 60099 County: LAKE Telephone Number: (847) 746-8385 Fax #: (847) 746-3545 HFS ID Number: Date of Initial License for Current Owners: 9/01/1979 Type of Ownership: ☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501C(3) ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: JAMES S. STEFO, SR. Telephone Number: (847) 456-6681

Email Address:

Facility Name & ID Number ROLLING HILLS MANOR

0025239 Report Period Beginning: 11/01/2010 Ending: 10/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 7/01/2011

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>127</u>	Skilled (SNF)	<u>115</u>	<u>44,879</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>127</u>	TOTALS	<u>115</u>	<u>44,879</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,243</u>	<u>11,604</u>	<u>12,987</u>	<u>40,834</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,243</u>	<u>11,604</u>	<u>12,987</u>	<u>40,834</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.99%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 9/01/1979

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 9/01/1979 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 115 and days of care provided 12,987

Medicare Intermediary WPS MEDICARE

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 10/31/2011 Fiscal Year: 10/31/2011
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **ROLLING HILLS MANOR** # **0025239** Report Period Beginning: **11/01/2010** Ending: **10/31/2011**

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	350,129	46,381	43,254	439,764		439,764		439,764			1
2	Food Purchase		241,242		241,242	(25,301)	215,941	(2,252)	213,689			2
3	Housekeeping	276,000	49,820		325,820		325,820		325,820			3
4	Laundry	180,457	16,444	21,521	218,422		218,422		218,422			4
5	Heat and Other Utilities			218,183	218,183		218,183		218,183			5
6	Maintenance	202,521	33,535	118,209	354,265		354,265		354,265			6
7	Other (specify):*			909,916	909,916		909,916	(909,916)				7
8	TOTAL General Services	1,009,107	387,422	1,311,083	2,707,612	(25,301)	2,682,311	(912,168)	1,770,143			8
	B. Health Care and Programs											
9	Medical Director			16,250	16,250		16,250		16,250			9
10	Nursing and Medical Records	3,958,773	190,529	601,257	4,750,559	(466,308)	4,284,251		4,284,251			10
10a	Therapy			1,435,734	1,435,734		1,435,734		1,435,734			10a
11	Activities	113,031	9,247	8,305	130,583		130,583		130,583			11
12	Social Services	85,820	1,050	2,954	89,824		89,824		89,824			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			444,800	444,800		444,800	(444,800)				15
16	TOTAL Health Care and Programs	4,157,624	200,826	2,509,300	6,867,750	(466,308)	6,401,442	(444,800)	5,956,642			16
	C. General Administration											
17	Administrative	206,283		32,976	239,259		239,259	(32,976)	206,283			17
18	Directors Fees			13,600	13,600		13,600		13,600			18
19	Professional Services			120,672	120,672		120,672		120,672			19
20	Dues, Fees, Subscriptions & Promotions			47,062	47,062		47,062	(12,818)	34,244			20
21	Clerical & General Office Expenses	436,396	67,601	180,324	684,321		684,321	(66,356)	617,965			21
22	Employee Benefits & Payroll Taxes			1,033,222	1,033,222	25,301	1,058,523	(8,211)	1,050,312			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,974	15,974		15,974		15,974			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,633	77,633		77,633	17,011	94,644			26
27	Other (specify):*			678,934	678,934		678,934	(678,934)				27
28	TOTAL General Administration	642,679	67,601	2,200,397	2,910,677	25,301	2,935,978	(782,284)	2,153,694			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,809,410	655,849	6,020,780	12,486,039	(466,308)	12,019,731	(2,139,252)	9,880,479			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			255,714	255,714		255,714	13,728	269,442			30
31	Amortization of Pre-Op. & Org.											31
32	Interest and Bond Costs			100,711	100,711		100,711	(65,273)	35,438			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			456,505	456,505		456,505	(456,505)				36
37	TOTAL Ownership			812,930	812,930		812,930	(508,050)	304,880			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			63,475	63,475		63,475		63,475			42
43	Other (specify):* Prescripton Drugs					466,308	466,308		466,308			43
44	TOTAL Special Cost Centers			63,475	63,475	466,308	529,783		529,783			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,809,410	655,849	6,897,185	13,362,444		13,362,444	(2,647,302)	10,715,142			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,211)	22		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	13,728	30		9
10	Interest and Other Investment Income	(65,273)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,252)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,976)	17		24
25	Fund Raising, Advertising and Promotional	(12,818)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,802)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	(2,539,500)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,539,500)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,647,302)		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 Yes	2 No	3 Amount	4 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	X		466,308	10:3	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 466,308		47

Report Period Beginning:

Ending:

ID#

0025239

11/01/2010

10/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary B

10/31/2011

	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
Capital Expense	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
D. Ownership												(to Sch V, col.7)	
Depreciation	13,728	0	0		0	0	0	0	0	0	0	13,728	30
Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
Interest	(65,273)	0	0		0	0	0	0	0	0	0	(65,273)	32
Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
Rent-Facility & Grounds	0	0	0		0	0	0	0	0	0	0	0	34
Rent-Equipment & Vehicles	0	0	0		0	0	0	0	0	0	0	0	35
Other (specify):*	0	(456,505)	0		0	0	0	0	0	0	0	(456,505)	36
TOTAL Ownership	(51,545)	(456,505)	0	0	0	0	0	0	0	0	0	(508,050)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation	0	0	0		0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	0	0		0	0	0	0	0	0	0	0	39
Barber and Beauty Shops	0	0	0		0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0		0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0		0	0	0	0	0	0	0	0	42
Other (specify):*	0	0	0		0	0	0	0	0	0	0		43
TOTAL Special Cost Centers	0	0	0		0	0	0	0	0	0	0	0	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(107,802)	(2,539,500)	0		0	0	0	0	0	0	0	(2,647,302)	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
A Slovak American Charitable Association	100	N/A	N/A	N/A	N/A	N/A
N/A		N/A	N/A	Rolling Hills Place	Zion, Illinois	Assisted Living Facility

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)	
1	V	21	Administrative Expenses	\$ 66,356	Slovak American Charitable Association		\$	\$ (66,356)	1
2	V	26	Liability Insurance	(17,011)	Slovak American Charitable Association			17,011	2
3	V	7	General Services	909,916	Rolling Hills Place			(909,916)	3
4	V	15	Healthcare and Programs	444,800	Rolling Hills Place			(444,800)	4
5	V	27	General Admnistration	678,934	Rolling Hills Place			(678,934)	5
6	V	36	Capital Expenses	456,505	Rolling Hills Place			(456,505)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,539,500			\$	\$ * (2,539,500)	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								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			\$			\$ NONE	\$ *	39

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

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 ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2010 Ending: 10/31/2011

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	JAMES STEFO, JR.	DIRECTOR	PRESIDENT	NONE	NONE	1/2 HR.	2.00	DIR. FEE	\$ 2,300		1
2	ANNE LESAK SCOTT	DIRECTOR	VICE PRES.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,300		2
3	JANET PILCH	DIRECTOR	TEASURER	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,300		3
4	DOROTHY MITCHELL	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,300		4
5	ELEANOR PETRAS	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,300		5
6	MARION STEFO	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,100		6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,600		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 ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2010 Ending: 0/31/2011

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					\$ NONE	\$ NONE		\$ NONE	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		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	IDFA REVENUE BONDS			REFINANCING OF SERIES			\$					\$	1			
2	SERIES 2000		X	1996 BONDS	\$12,200.00	6/20/2000		2,600,000	2,097,439	6/29/2030	4.1700	89,823	2			
3													3			
4													4			
5													5			
	Working Capital															
6													6			
7													7			
8													8			
9	TOTAL Facility Related				\$12,200.00		\$	2,600,000	\$	2,097,439			\$	89,823	9	
	B. Non-Facility Related*															
10														10		
11														11		
12														12		
13														13		
14	TOTAL Non-Facility Related						\$		\$				\$		14	
15	TOTALS (line 9+line14)							\$	2,600,000	\$	2,097,439			\$	89,823	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	NONE	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.)		\$	NONE	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	NONE	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	NONE	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.)		\$	NONE	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.)		\$	NONE	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	#VALUE!	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	NONE	8	
		2007	NONE	9	
		2008	NONE	10	
		2009	NONE	11	
		2010	NONE	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010 \$	13	
		14	PLUS APPEAL COST FROM LINE 5 \$	14	
		15	LESS REFUND FROM LINE 6 \$	15	
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16	

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

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>ROLLING HILLS MANOR</u>	COUNTY	<u>LAKE</u>
---------------	----------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0025239

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,632

B. General Construction Type: Exterior BRICK Frame N/A Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ROLLING HILLS PLACE

ASSISTED LIVING FACILITY

69 BEDS / UNITS

48,000 SQUARE FEET

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

If so, please complete the following:

1. Total Amount Incurred: 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: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>3 ACRES</u>	<u>1979</u>	<u>\$ 100,763</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	3 ACRES		\$ 100,763	3

Facility Name & ID Number **ROLLING HILLS MANOR**

0025239

Report Period Beginning:

11/01/2010

Ending:

10/31/2011

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	115		1979	1970	\$ 927,078	\$ 9,449	40	\$ 23,177	\$ 13,728	\$ 871,152	4
5			1979	1970	712,648	20,361	35	20,361		651,564	5
6			1992	1992	1,234,270	30,857	40	30,857		601,708	6
7			1992	1992	232,299		10			232,299	7
8			1998	1998	695,702	17,393	40	17,393		226,873	8
	Improvement Type**										
9	AIRLOCKS			1982	3,886		20			3,886	9
10	ROOF			1983	41,724		20			41,724	10
11	PLUMBING FIXTURES			1983	3,845		20			3,845	11
12	ROOF AND HEATER			1984	118,647		20			118,647	12
13	SURFACING AND DRAINAGE			1984	37,141		10			37,141	13
14	SHRUBBEERY			1985	1,061		10			1,061	14
15	RAMP			1985	38,992		20			38,992	15
16	MIXING VALVE			1985	325		20			325	16
17	FENCE			1986	1,257		20			1,257	17
18	RAMP			1986	5,400		20			5,400	18
19	ROOF			1986	33,997		20			33,997	19
20	HEATING UNITS			1988	6,344		3			6,344	20
21	FLOOD DEVICE			1989	7,418		10			7,418	21
22	ELECTRIC PANELS			1989	6,354		5			6,354	22
23	HALLWAY LIGHTING			1990	8,091		10			8,091	23
24	ALARM SYSTEM			1991	6,775		10			6,775	24
25	PELLA WINDOWS			1992	4,367		10			4,367	25
26	PELLA WINDOWS			1992	3,661		5			3,661	26
27	ROOF			1993	24,500		10			24,500	27
28	PELLA WINDOWS			1993	14,624	731	20	731		13,526	28
29	ROOF			1994	24,500		10			24,500	29
30	HEATING UNITS			1994	6,987		10			6,987	30
31	WATER LINE			1994	6,820	341	20	341		5,968	31
32	PARKING LOT SURFACING			1994	4,346	217	20	217		3,083	32
33	ROOF			1995	24,800		10			24,800	33
34	HOT WATER SYSTEM			1995	18,175		10			18,175	34
35	DOOR LOCKS			1995	12,473		10			12,473	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2010 Ending: 10/31/2011

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	CALL LIGHTING SYSTEM	1996	\$ 14,321	\$	10	\$	\$	\$ 14,321	37
38	RETAINING WALL	1996	38,975	1,949	20	1,949		30,207	38
39	OXYGEN ENVIRONMENT	1996	3,892		10			3,892	39
40	EMERGENCY GENERATOR	1996	10,089	334	15	334		10,089	40
41	CANOPIES	1997	2,490		10			2,490	41
42	KITCHEN TILING	1997	3,507		10			3,507	42
43	AIR CONDITIONING	1997	5,970		10			5,970	43
44	ROOF	1998	5,500		10			5,500	44
45	SIGN	1999	2,768	69	40	69		898	45
46	SIGN	1999	4,668	117	40	117		1,519	46
47	PELLA WINDOWS	1999	7,855	393	20	393		4,911	47
48	CARPETING AND WALLPAPER	2000	9,279	464	15	464		8,121	48
49	SMOKE DETECTORS	2000	12,985	649	15	649		9,038	49
50	ROOF	2000	12,585	629	20	629		7,236	50
51	SEWER EXTENSION	2000	11,480	574	20	574		6,601	51
52	SHRUBBERY	2001	2,211	147	15	147		1,545	52
53	PAINT AND WALLPAPER	2001	1,510	75	10	75		1,510	53
54	VINYOL FLOORING	2001	9,602	481	10	481		9,602	54
55	CARPETING AND WALLPAPER	2001	17,556	875	10	875		17,556	55
56	HAND RAILS	2001	11,425	571	20	571		5,996	56
57	PRESSURE VALVE	2001	4,636	232	20	232		2,435	57
58	EXHAUST FANS	2001	3,994	200	20	200		2,099	58
59	CARPETING AND TILE	2002	80,772	8,077	10	8,077		76,732	59
60	HAND RAILS	2002	28,365	1,418	40	1,418		13,472	60
61	CLASSROOM FLOORS AND WALLS	2002	2,970	149	40	149		1,414	61
62	WOOD COLUMNS	2002	7,050	353	40	353		3,352	62
63	FLOOR OUTLETS	2002	4,606	230	40	230		2,186	63
64	DOOR	2002	7,360	368	40	368		3,496	64
65	VINYL FLOORING	2003	29,600	2,960	10	2,960		25,160	65
66	DOORS	2003	6,835	342	40	342		2,910	66
67	SIDEWALKS	2003	4,352	218	40	218		1,852	67
68	SHRUBBERY	2004	5,000	500	10	500		3,750	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,642,715	\$ 101,723		\$ 115,451	\$ 13,728	\$ 3,336,260	70

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

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2010 Ending: 10/31/2011

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		\$ 4,642,715	\$ 101,723		\$ 115,451	\$ 13,728	\$ 3,336,260	1
2	<u>CARPETING</u>	2004	27,900	2,790	10	2,790		20,925	2
3	<u>DOORS</u>	2004	11,800	590	20	590		4,425	3
4	<u>DOORS</u>	2005	3,372	169	20	169		1,096	4
5	<u>WLL GUARDS AND RAILS</u>	2005	3,540	354	10	354		2,301	5
6	<u>VENTILATING DAMPERS</u>	2005	3,538	236	15	236		1,534	6
7	<u>DOOR PLATES AND LOCKS</u>	2005	3,525	176	20	176		1,144	7
8	<u>SIGNS</u>	2005	3,662	366	10	366		2,379	8
9	<u>SENSOR SECURITY SYSTEM</u>	2005	24,322	1,216	20	1,216		7,904	9
10	<u>TELEPHONE CIRCUITRY</u>	2005	5,483	366	15	366		2,377	10
11	<u>FLOORING</u>	2005	1,500	150	10	150		975	11
12	<u>ALARM SYSTEM</u>	2005	1,527	153	10	153		994	12
13	<u>TELEPHONE CIRCUITRY</u>	2005	2,163	144	15	144		936	13
14	<u>WATER LINES AND BOILER</u>	2005	33,140	1,657	20	1,657		10,771	14
15	<u>HVAC UNIT</u>	2005	9,280	238	39	238		1,448	15
16	<u>HVAC UNIT</u>	2005	7,925	793	10	793		5,152	16
17	<u>FLOORING</u>	2006	7,148	715	10	715		4,648	17
18	<u>ELECTRIC PANEL</u>	2006	1,100	55	20	55		303	18
19	<u>FREEZER CIRCUITRY</u>	2006	1,986	132	15	132		726	19
20	<u>ELEVATOR HYDRAULICS RENOVATION</u>	2006	33,276	1,664	20	1,664		9,152	20
21	<u>DOOR LOCKS</u>	2006	1,830	92	20	92		506	21
22	<u>CRASH RAILS</u>	2006	578	29	20	29		159	22
23	<u>BOILER PIPING</u>	2006	1,742	87	20	87		479	23
24	<u>SKYLIGHTS</u>	2006	3,205	160	20	160		880	24
25	<u>SIDEWALKS</u>	2006	1,400	70	20	70		385	25
26	<u>GENERATOR ELECTRIC SYSTEM</u>	2006	1,336	134	10	134		737	26
27	<u>PARKING LOT SURFACING</u>	2006	2,985	298	5	298		2,985	27
28	<u>ELEVATOR LIGHTING</u>	2006	1,527	76	20	76		405	28
29	<u>WALK IN FREEZER</u>	2006	33,813	1,691	20	1,691		9,300	29
30	<u>SHRUBBERY</u>	2006	4,512	451	10	451		2,311	30
31	<u>100 WING - ELECTRICAL</u>	2006	18,869	943	20	943		5,187	31
32	<u>100 WING - LIGHTING</u>	2006	4,106	205	20	205		1,127	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,904,805	\$ 117,923		\$ 131,651	\$ 13,728	\$ 3,439,911	34

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

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2010 Ending: 10/31/2011

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 12B, Carried Forward		\$ 4,904,805	\$ 117,923		\$ 131,651	\$ 13,728	\$ 3,439,911	1
2	100 WING - CARPENTRY AND DOORS	2006	6,625	331	20	331		1,820	2
3	100 WING - FLOORINGG	2006	4,550	228	20	228		1,254	3
4	100 WING - PLUMBING	2006	1,742	88	20	88		484	4
5	100 WING - PAINTING AND WALLPAPER	2006	8,198	410	20	410		2,255	5
6	SEWERS	2007	31,553	1,578	20	1,578		7,101	6
7	P LUMBING CONNECTIONS	2007	3,384	169	20	169		761	7
8	SPRINKLER SYSTEM	2007	31,188	1,536	20	1,536		6,992	8
9	KITCHEN TILING	2007	1,420	142	10	142		639	9
10	THERMOSTATS	2007	3,585	358	10	358		1,611	10
11	DOORS AND LOCKS	2007	12,180	609	20	609		2,761	11
12	WINDOW TREATMENTS	2007	1,800	180	10	180		810	12
13	COLUMN CAPS	2007	7,534	377	20	377		1,994	13
14	ROOFING	2007	1,050	53	20	53		237	14
15	AUTOMATIC DOORS	2007	2,972	149	20	149		670	15
16	ELECTRICAL PANEL	2007	9,128	456	20	456		2,052	16
17	HAND RAILS	2007	3,200	160	20	160		720	17
18	100 WING - LIGHTING	2007	5,450	272	20	272		1,224	18
19	100 WING - DOORS	2007	3,885	194	20	194		873	19
20	100 WING - PAINTING AND WALLPAPER	2007	1,596	80	20	80		360	20
21	FIRE ALARM SYSTEM	2008	15,772	789	20	789		2,761	21
22	AIR CONDITIONING UNIT	2008	1,700	170	10	170		595	22
23	WATER LINE	2008	14,210	474	30	474		1,659	23
24	CIRCUIT BREAKERS	2008	1,140	57	20	57		199	24
25	HEAT PUMP	2008	6,525	653	10	653		2,285	25
26	KITCHEN TILING	2008	1,018	51	20	51		178	26
27	SPRINKLER SYSTEM	2008	3,986	199	20	199		697	27
28	STORAGE ROOM DOORS	2008	12,170	609	20	609		2,131	28
29	CARPETING	2008	2,825	283	10	283		990	29
30	CARPETING	2008	2,580	258	10	258		903	30
31	WALL PANELS	2008	3,267	163	20	163		571	31
32	MAINTENANCE SINK	2008	965	48	20	48		168	32
33		2008							33
34	TOTAL (lines 1 thru 33)		\$ 5,112,003	\$ 129,047		\$ 142,775	\$ 13,728	\$ 3,487,666	34

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

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2010 Ending: 10/31/2011

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 12C, Carried Forward		\$ 5,112,003	\$ 129,047		\$ 142,775	\$ 13,728	\$ 3,487,666	1
2	SPRINKLER SYSTEM	2008	1,155	30	39	30		118	2
3	STORAGE ROOM DOORS	2008	3,958	101	39	101		402	3
4	DOOR LOCKS	2008	3,358	168	20	168		588	4
5	BOILER AND WATER TANKS	2008	11,920	596	20	596		2,084	5
6	RETAINING WALL	2008	46,418	2,321	20	2,321		8,053	6
7	DOORS AND LOCKS	2008	1,939	97	20	97		339	7
8	DRYER EXHAUST VENTS	2008	4,313	431	10	431		1,509	8
9	CARPETING	2008	3,600	360	10	360		1,260	9
10	LANDSCAPING AND SHRUBBERY	2008	18,783	939	20	939		3,287	10
11	ELEVATOR - ELECTRICAL	2009	58,435	1,498	39	1,498		3,745	11
12	WATER LINE PIPING	2009	15,146	388	39	388		970	12
13	FIRE ALARM SYSTEM	2009	15,302	392	39	392		1,013	13
14	SKYLIGHTS	2009	9,175	458	20	458		1,145	14
15	FLOORING	2009	2,092	209	10	209		523	15
16	FIRE ALARM SYSTEM	2009	5,273	135	39	135		338	16
17	NRSE CALL STATION SYSTEM	2009	5,186	132	39	132		330	17
18	TELEPHONE LINES	2009	3,810	381	10	381		953	18
19	LOBBY AND HALLWAY CARPETING	2009	37,322	2,488	15	2,488		6,212	19
20	LOBBY WINDOW TREATMENTS AND DOORS	2009	10,884	726	15	726		1,812	20
21	LOBBY HALLWAY WALL REFINISHING	2009	19,249	1,283	15	1,283		3,204	21
22	LOBBY CABINETRY AND PANELS	2009	23,229	1,549	15	1,549		3,867	22
23	FIRE ALARM SYSTEM	2009	758	19	39	19		48	23
24	DRIVEWAY TO ROUTE 173	2009	119,776	3,071	39	3,071		7,678	24
25	PARKING LOT PAVING	2009	8,499	567	15	567		1,417	25
26	PARKING LOT STRIPING	2009	4,495	300	15	300		750	26
27	A/C COMPRESSOR	2009	3,348	334	10	334		835	27
28	PLUMBING AND HOT WATER TANK	2009	5,532	142	39	142		354	28
29	SUMP DRAIN	2010	1,200	60	20	60		90	29
30	FLOORING - BEAUTY SHOP	2010	4,182	418	10	418		627	30
31	FIXTURES - BEAUTY SHOP	2010	3,025	148	20	148		222	31
32	FIRE SYSTEM FAN	2010	13,477	346	39	346		519	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,576,842	\$ 149,134		\$ 162,862	\$ 13,728	\$ 3,541,958	34

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

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2010 Ending: 10/31/2011

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 12D, Carried Forward		\$ 5,576,842	\$ 149,134		\$ 162,862	\$ 13,728	\$ 3,541,958	1
2	SAFETY UNITS	2010	1,400	140	10	140		210	2
3	WATER MAIN	2010	19,875	510	39	510		765	3
4	LOBBY FLOORING	2010	1,737	174	10	174		261	4
5	STORM DRAIN	2010	4,072	104	39	104		156	5
6	KITCHEN CEILING	2010	25,291	1,686	15	1,686		2,529	6
7	FLOORING - DINING ROOM	2010	30,348	3,034	10	3,034		4,551	7
8	WOMENS' BATHROOM	2010	2,134	214	10	214		321	8
9	ROOFING A/C UNIT	2010	4,120	412	10	412		618	9
10	FLOORING -EAST ACTIVITY ROOM	2010	22,731	2,274	10	2,274		3,411	10
11	KITCHEN CABINETRY	2010	754	76	10	76		114	11
12	TELEPHONECABELING	2010	875	44	20	44		66	12
13	LANDSCAPING	2010	1,940	98	20	98		147	13
14	PARKING LOT SEWEWS AND DRAINS	2011	9,020	226	20	226		226	14
15	PARKING LOT PAIVING	2011	10,308	258	20	258		258	15
16	LANDSCAPING	2011	3,141	78	20	78		78	16
17	CONCRETE CURBS	2011	9,526	238	20	238		238	17
18	PARKING LOT PAVING AND RESURFACING	2011	43,555	726	30	726		726	18
19	PARKING LOT EXCAVATION	2011	137,968	2,299	30	2,299		2,299	19
20	SHRUBBERY AND LANDSCAPING	2011	38,289	957	20	957		957	20
21	FENCING	2011	9,069	227	20	227		227	21
22	WALL RESTORATION	2011	3,000	50	15	50		50	22
23	KITCHEN TILING	2011	2,100	105	10	105		105	23
24	SRU TELEPHONE SYSTEM	2011	59,780	1,993	15	1,993		1,993	24
25	CORE ROOFING	2011	83,325	2,083	20	2,083		2,083	25
26	WIFI	2011	4,241	106	20	106		106	26
27	FIRE CONTROLS	2011	9,488	237	20	237		237	27
28	FLOORING AND BORDERS	2011	5,060	253	10	253		253	28
29	WALL LAMBS	2011	5,630	188	15	188		188	29
30	FLOORING AND TRIM	2011	13,575	679	10	679		679	30
31	RAILS AND MOLDINGS	2011	12,150	304	20	304		304	31
32	ROOF A/C	2011	2,455	123	10	123		123	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,153,799	\$ 169,030		\$ 182,758	\$ 13,728	\$ 3,566,237	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 Totals from Page 12E, Carried Forward		\$ 6,153,799	\$ 169,030		\$ 182,758	\$ 13,728	\$ 3,566,237	1
2 HALLWAY CARPETING	2011	44,500	1,236	15	1,236		1,236	2
3 FREEZER RAMP	2011	4,143	104	20	104		104	3
4 CARPETING - 300 HALL	2011	28,451	182	39	182		182	4
5 ALARM SYSTEM	2011	3,103	20	39	20		20	5
6 SPRINKLERS	2011	6,787	87	39	87		87	6
7 SOLOTUBING	2011	2,013	101	10	101		101	7
8 WINDOW TEATMENTS	2011	1,371	69	10	69		69	8
9 FLOOGIN - 400 HAL	2011	13,575	1,471	39	1,471		1,471	9
10 LOBBY ABATEMENT	2011	57,381	3,678	20	3,678		3,678	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 TOTAL (lines 1 thru 33)		\$ 6,315,123	\$ 175,978		\$ 189,706	\$ 13,728	\$ 3,573,185	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	\$615,008	\$68,267	\$68,267	\$	3-15 yrs	\$377,137	71
72	Current Year Purchases	164,920	8,480	8,480		3-15 yrs	8,480	72
73	Fully Depreciated Assets	1,412,070	604	604		3-15 yrs	1,412,070	73
74								74
75	TOTALS	\$2,191,998	\$77,351	\$77,351	\$		\$1,797,687	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	BUSINESS	1995 FORD EL DORADO	1995	\$40,018	\$	\$	\$	7	\$40,018	76
77	BUSINESS	2010 FORD VAN	2010	23,846	2,385	2,385		10	3,577	77
78										78
79										79
80	TOTALS			\$63,864	\$2,385	\$2,385	\$		\$43,595	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$8,671,748	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$255,714	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$269,442	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$13,728	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,414,467	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ NONE	\$	\$ NONE	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$ NONE	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- YES

X

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

**

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
- NONE

9. Option to Buy:
- YES

X

NO
- Terms: N/A
- *

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

15. Is Movable equipment rental included in building rental?
- YES

X

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		\$ N/A	\$ N/A	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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	\$	\$ NONE	\$ NONE	\$ NONE
10	SUM OF line 9, col. 1 and 2 (e)	\$	NONE		

- (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.

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	NONE

- (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.)

	1	2	3	4	5	6	7	8		
	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	10a:8	hrs	\$	561,669	\$ 617,836	\$	561,669	\$ 617,836	1
2	Licensed Speech and Language Development Therapist	10a:8	hrs		82,481	90,729		82,481	90,729	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a:8	hrs		660,077	726,085		660,077	726,085	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	10a:8	hrs		985	1,084		985	1,084	8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	1,238,564	\$ 1,435,734	\$	1,305,212	\$ 1,435,734	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	\$ 762,052	\$ 1,134,684	1
2	Cash-Patient Deposits	9,094	9,094	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,498,761	1,530,630	3
4	Supply Inventory (priced at COST)	269,410	324,832	4
5	Short-Term Investments			5
6	Prepaid Insurance	50,020	51,900	6
7	Other Prepaid Expenses	71,476	89,068	7
8	Accounts Receivable (owners or related parties)	58,410		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,719,223	\$ 3,140,208	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,765,079	12
13	Land	100,763	236,453	13
14	Buildings, at Historical Cost	6,315,123	13,260,567	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,255,862	3,168,110	16
17	Accumulated Depreciation (book methods)	(5,414,467)	(7,723,142)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	256,070	660,510	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(99,156)	(246,137)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,414,195	\$ 11,121,440	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,133,418	\$ 14,261,648	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 632,996	\$ 747,502	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,094	9,094	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	530,407	565,497	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,074	19,156	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Resident and other credits	71,820	235,670	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,250,391	\$ 1,576,919	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,097,439	6,615,000	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)	\$ 2,097,439	\$ 6,615,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,347,830	\$ 8,191,919	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,785,588	\$ 6,069,729	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,133,418	\$ 14,261,648	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,915,392	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,915,392	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,154,337	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)	\$ 1,154,337	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)	\$ 6,069,729	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**Report Period Beginning: **11/01/2010**Ending: **10/31/2011**

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,900,697	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,900,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,478,746	6
7	Oxygen	63,186	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,541,932	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,211	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)	\$ 8,211	23
	D. Non-Operating Revenue		
24	Contributions	7,653	24
25	Interest and Other Investment Income***	65,273	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 72,926	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Realized gain on investments	43,316	28
28a	Unrealized loss on investments	(50,301)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (6,985)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,516,781	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,707,612	31
32	Health Care	6,867,750	32
33	General Administration	2,910,677	33
	B. Capital Expense		
34	Ownership	812,930	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	63,475	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,362,444	40
41	Income before Income Taxes (line 30 minus line 40)**	1,154,337	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,154,337	43

* 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.

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	1,944	2,240	\$ 70,920	\$ 31.66	1
2	Assistant Director of Nursing	1,864	2,046	67,626	33.05	2
3	Registered Nurses	31,528	34,624	1,124,834	32.49	3
4	Licensed Practical Nurses	22,046	24,186	663,144	27.42	4
5	CNAs & Orderlies	131,648	142,167	1,767,843	12.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,402	6,110	83,929	13.74	8
9	Activity Director	2,008	2,224	48,885	21.98	9
10	Activity Assistants	5,667	6,156	64,146	10.42	10
11	Social Service Workers	3,436	3,873	85,820	22.16	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,240	58,763	26.23	13
14	Head Cook	4,098	4,706	111,106	23.61	14
15	Cook Helpers/Assistants	18,714	20,798	180,260	8.67	15
16	Dishwashers					16
17	Maintenance Workers	15,831	17,394	202,521	11.64	17
18	Housekeepers	25,871	28,571	276,000	9.66	18
19	Laundry	16,942	18,708	180,457	9.65	19
20	Administrator	1,956	2,116	101,718	48.07	20
21	Assistant Administrator					21
22	Other Administrative	9,712	10,535	181,354	17.21	22
23	Office Manager	1,972	2,200	68,458	31.12	23
24	Clerical	8,731	9,415	186,584	19.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,995	2,075	63,765	30.73	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,259	2,441	36,665	15.02	31
32	MDS Coordinator	1,944	2,479	80,047	32.29	32
33	Executive Director	1,896	2,080	104,565	50.27	33
34	TOTAL (lines 1 - 33)	319,512	349,384	\$ 5,809,410 *	\$ 16.63	34

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	1,640	\$ 41,002	1:3	35
36	Medical Director	217	16,250	9:3	36
37	Medical Records Consultant	133	3,315	10:3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	1,098	11:3	44
45	Social Service Consultant	84	2,954	12:3	45
46	Rehab Consultant	257	12,850	10:3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,375	\$ 77,469		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)		\$ NONE		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

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
Miron Tabic	Administrator	None	\$ 101,718	Workers' Compensation Insurance	\$	119,003	IDPH License Fee	\$ 16,604
James S.Stefo, Sr.	Executive Director	None	104,565	Unemployment Compensation Insurance		13,774	Advertising: Employee Recruitment	5,545
				FICA Taxes		428,658	Health Care Worker Background Check	
				Employee Health Insurance		352,489	(Indicate # of checks performed 180)	4,510
				Employee Meals		25,301	Patient Background Checks 125	3,125
				Illinois Municipal Retirement Fund (IMRF)*			Illinois Council for Long Term Care	9,577
				Employee Life and Disabiity Insurance		39,260	Meemberships	938
				PTO Expense		28,573	Inspections and Fees	6,763
				Employee Retirement Funding		51,465		
				Employee Meal Reimbursement		(8,211)		
							Less: Public Relations Expense	()
							Non-allowable advertising	(12,818)
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 206,283					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$	1,050,312		\$ 34,244
Bad Debt Expense			\$ 32,976					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
			\$ 32,976	Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Frost and Ruttingberg	General Audit		\$ 23,435					
Frost and Ruttingberg	401K Audit		6,000					
James S. Stefo and Co.	Accounting		7,020					
McGladry and Pullen	MDS Consultation		1,850				In-State Travel	
Polsinelli and Shughart	Legal		53,033				Automotive Expense	834
Smith Amundsen	Legal		2,334				Travel Reimbursement	3,193
Abrams and Aabrams	Imagtec Settlement		7,000					
Askounis and Darcy	GE Settlement		20,000				Seminar Expense	11,947
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$ NONE	TOTAL (line 24, col. 8)	\$ 15,974
			\$ 120,672					

* Attach copy of IMRF notifications

**See instructions.

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.

IL COUNCIL LONG TERM CARE \$9,577

(3)

Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

YES

If YES, what is the capacity?

115

(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?

5-10 YRS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 72,057

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

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

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.

\$ 63,475

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.

\$ 25,301

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$ 8,211

(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?

100

d. Have vehicle usage logs been maintained?

YES

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ NONE

(17)

Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name:

FROST AND RUTTENBERG

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

YES

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V COLUMN 5 LINES 2 AND 22

\$25,301 OF EMPLOYEE MEALS HAVE BEEN DEDUCTED FROM LINE2 (FOOD COSTS)
AND HAVE BEEN ADDED TO LINE 22 (EMPLOYEE BENEFITS).

SCHEDULE V COLUMN 5 LINES 10 AND 43

\$466,308 OF PRESCRIPTION DRUG COSTS HAVE BEEN DEDUCTED FOR LINE 10
(NURSING COSTS) AND HAVE BEEN ADDED TO LINE 43 (SPECIAL COST CENTERS).