

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0051177 Facility Name: Elmbrook Nursing Address: 127 West Diversy Elmhurst 60126 Number City Zip Code County: Dupage Telephone Number: (630)530-5225 Fax #: (630)530-7775 HFS ID Number: Date of Initial License for Current Owners: 10/01/10 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Date) (Type or Print Name) (Title) Paid Preparer (Signed) (Date) (Print Name and Title) Kimberley A. Waite, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax #: (847) 236-1155 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>176</u>	Skilled (SNF)	<u>176</u>	<u>64,416</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>4</u>	Intermediate (ICF)	<u>4</u>	<u>1,464</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,880</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,528</u>	<u>2,637</u>	<u>13,706</u>	<u>28,871</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>26,867</u>	<u>2,081</u>	<u>576</u>	<u>29,524</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,395</u>	<u>4,718</u>	<u>14,282</u>	<u>58,395</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.64%

D. How many bed-hold days during this year were paid by the Department? None (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 10/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/1/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 176 and days of care provided 13,136

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	352,480	40,541	16,574	409,595		409,595		409,595			1
2	Food Purchase		358,418		358,418	(46,907)	311,511	(265)	311,247			2
3	Housekeeping	261,799	26,219	837	288,855		288,855	1,113	289,968			3
4	Laundry	68,566	21,866		90,432		90,432		90,432			4
5	Heat and Other Utilities			218,060	218,060		218,060	(3,744)	214,316			5
6	Maintenance	104,821	2,838	106,508	214,167		214,167	14,563	228,730			6
7	Other (specify):*											7
8	TOTAL General Services	787,666	449,882	341,979	1,579,527	(46,907)	1,532,620	11,667	1,544,288			8
	B. Health Care and Programs											
9	Medical Director			39,050	39,050		39,050		39,050			9
10	Nursing and Medical Records	3,258,040	264,449	84,082	3,606,571		3,606,571	(58,304)	3,548,267			10
10a	Therapy	202,309	(184)		202,125		202,125		202,125			10a
11	Activities	198,516	13,934		212,450		212,450		212,450			11
12	Social Services	55,057		714	55,771		55,771	2,412	58,183			12
13	CNA Training											13
14	Program Transportation			2,030	2,030		2,030		2,030			14
15	Other (specify):*							1,579	1,579			15
16	TOTAL Health Care and Programs	3,713,922	278,199	125,876	4,117,997		4,117,997	(54,313)	4,063,684			16
	C. General Administration											
17	Administrative	302,029		16,000	318,029		318,029	24,591	342,620			17
18	Directors Fees											18
19	Professional Services			369,799	369,799		369,799	(251,001)	118,798			19
20	Dues, Fees, Subscriptions & Promotions			201,917	201,917		201,917	(170,847)	31,070			20
21	Clerical & General Office Expenses	132,799	4,286	426,933	564,018		564,018	(227,137)	336,881			21
22	Employee Benefits & Payroll Taxes			791,089	791,089	46,907	837,996		837,996			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,259	1,259		1,259	202	1,461			24
25	Other Admin. Staff Transportation			2,986	2,986		2,986		2,986			25
26	Insurance-Prop.Liab.Malpractice			116,901	116,901		116,901	707	117,608			26
27	Other (specify):*							25,581	25,581			27
28	TOTAL General Administration	434,828	4,286	1,926,884	2,365,998	46,907	2,412,905	(597,903)	1,815,002			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,936,416	732,367	2,394,739	8,063,522		8,063,522	(640,549)	7,422,973			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			436,172	436,172		436,172	287,480	723,652			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,532	53,532		53,532	740,998	794,530			32
33	Real Estate Taxes			61,729	61,729		61,729	4,071	65,800			33
34	Rent-Facility & Grounds			1,439,987	1,439,987		1,439,987	(1,436,668)	3,319			34
35	Rent-Equipment & Vehicles			4,594	4,594		4,594	132	4,726			35
36	Other (specify):*							46,100	46,100			36
37	TOTAL Ownership			1,996,014	1,996,014		1,996,014	(357,887)	1,638,127			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		484,305	1,267,900	1,752,205		1,752,205		1,752,205			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			387,918	387,918		387,918	(1,155)	386,763			42
43	Other (specify):*	53,729		679,157	732,886		732,886	(732,886)	0			43
44	TOTAL Special Cost Centers	53,729	484,305	2,334,975	2,873,009		2,873,009	(734,041)	2,138,968			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,990,145	1,216,672	6,725,728	12,932,545		12,932,545	(1,732,477)	11,200,068			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	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				4
5	Telephone, TV & Radio in Resident Rooms	(5,357)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	98,561	30		9
10	Interest and Other Investment Income	(796)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(290)	02		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	(191)	21		18
19	Entertainment				19
20	Contributions	(99,179)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(214,734)	21		24
25	Fund Raising, Advertising and Promotional	(62,668)	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	(1,031,390)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,316,043)		\$	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)	(416,434)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (416,434)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,732,477)		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					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Elmbrook Nursing

	ID#	0051177
Report Period Beginning:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Pharmacy - Veteran	\$ (15,698)	10	1
2	COPE Dues	(9,058)	20	2
3	Marketing Salary	(53,729)	43	3
4	Bank Charges	(7,949)	21	4
5	Building Co. - Accounting Fees	(2,000)	19	5
6	Building Co. - Closing Costs	(165)	21	6
7	Building Co. - Loan Fees	(99,078)	21	7
8	Building Co. - Professional Fees	(13,351)	19	8
9	Building Co. - State Income Tax	(587)	21	9
10				10
11	Additional R&M	11,932	06	11
12	Non-Allowable Legal	(12,645)	19	12
13				13
14	Non-Allowable Expense	(138,000)	21	14
15	Patient Personal Items	(262)	10	15
16	Discounts	(9,655)	21	16
17	Bed tax-Prior Period	(1,155)	42	17
18	Management Fees- Prior Period	(763)	21	18
19	Building Co.- Penalties	(70)	21	19
20	Non Allowable Expense	(679,157)	43	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,031,390)		49

Elmbrook Nursing

ID#

0051177

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supp		See Page 6 Supp		See Page 6 Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	34	Rental Income	\$ 1,436,668	Elmbrook Properties	100.00%	\$	(1,436,668)	1
2	V	32	Interest	7,482	Elmbrook Properties	100.00%	745,086	737,604	2
3	V	19	Accounting Fees		Elmbrook Properties	100.00%	2,000	2,000	3
4	V	30	Depreciation		Elmbrook Properties	100.00%	185,462	185,462	4
5	V	21	Closing Costs		Elmbrook Properties	100.00%	165	165	5
6	V	19	Legal-Acquisition Cost		Elmbrook Properties	100.00%	367	367	6
7	V	21	Loan Fees Expense		Elmbrook Properties	100.00%	99,078	99,078	7
8	V	19	Professional Fees		Elmbrook Properties	100.00%	12,984	12,984	8
9	V	06	Repairs & Maintenance		Elmbrook Properties	100.00%			9
10	V	21	State Income Tax		Elmbrook Properties	100.00%	587	587	10
11	V	36	Mortgage Insurance		Elmbrook Properties	100.00%	46,100	46,100	11
12	V	21	Penalties		Elmbrook Properties	100.00%	70	70	12
13	V								13
14	Total			\$ 1,444,150			\$ 1,091,899	\$ * (352,251)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	Legacy Healthcare Financial Services	100.00%	\$ 25	\$ 25	15
16	V	3	HOUSEKEEPING		Legacy Healthcare Financial Services	100.00%	1,113	1,113	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,613	1,613	17
18	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,631	2,631	18
19	V	17	MANAGEMENT FEES		Legacy Healthcare Financial Services	100.00%			19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	6,167	6,167	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	58	58	21
22	V	21	CLERICAL & GENERAL		Legacy Healthcare Financial Services	100.00%	143,883	143,883	22
23	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	202	202	23
24	V	25	AUTO AND TRAVEL		Legacy Healthcare Financial Services	100.00%			24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	707	707	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	21,061	21,061	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,148	1,148	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	5	5	28
29	V	33	REAL ESTATE TAX		Legacy Healthcare Financial Services	100.00%			29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	12,278	12,278	30
31	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%			31
32	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%			32
33	V	17	MANAGEMENT FEES	16,000	Legacy Healthcare Financial Services	100.00%		(16,000)	33
34	V	19	BOOKKEEPING FEES	244,683	Legacy Healthcare Financial Services	100.00%		(244,683)	34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	8,000	8,000	35
36	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	8,000	8,000	36
37	V	27	HEALTH INSURANCE/BENEFITS- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	2,260	2,260	37
38	V	27	HEALTH INSURANCE/BENEFITS- M. SHABAT		Legacy Healthcare Financial Services	100.00%	2,260	2,260	38
39	Total			\$ 260,683			\$ 211,411	\$ * (49,272)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	30	DEPRECIATION		Legacy Real Properties	100.00%	2,309	\$ 2,309	15
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	4,185	4,185	16
17	V	33	REAL ESTATE TAXES		Legacy Real Properties	100.00%	4,071	4,071	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V	34	RENT	12,278	Legacy Real Properties	100.00%		(12,278)	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			\$ 12,278			\$ 10,565	\$ * (1,713)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	5	UTILITIES	\$	Progressive Healthcare Consulting	100.00%	\$	\$	15
16	V	6	REPAIRS & MAINTENANCE		Progressive Healthcare Consulting	100.00%			16
17	V	10	RN SALARY	54,000	Progressive Healthcare Consulting	100.00%	11,656	(42,344)	17
18	V	12	CELRGY SALARY		Progressive Healthcare Consulting	100.00%	2,412	2,412	18
19	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	1,579	1,579	19
20	V	17	ADMIN		Progressive Healthcare Consulting	100.00%	24,591	24,591	20
21	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	160	160	21
22	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%			22
23	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	272	272	23
24	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%			24
25	V	25	AUTO AND TRAVEL		Progressive Healthcare Consulting	100.00%			25
26	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%			26
27	V	27	EMP. BEN.-GEN. ADMIN.		Progressive Healthcare Consulting	100.00%			27
28	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%			28
29	V	32	INTEREST		Progressive Healthcare Consulting	100.00%			29
30	V	33	REAL ESTATE TAX		Progressive Healthcare Consulting	100.00%			30
31	V	34	RENT		Progressive Healthcare Consulting	100.00%			31
32	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	132	132	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 54,000			\$ 40,802	\$ * (13,198)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$ *	39

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			\$			\$	\$ *	39

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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$ *	39

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	CHAIM RAJCHENBACH	25.000%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO	ELMBROOK PROPERTIES	ELMHURST	BUILDING CO	1
2	NACHY SHABAT	25.000%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO	LEGACY REAL PROPERTIES, L	LINCOLNWOOD	BUILDING CO	2
3	JIM KOUZIOUS	5.000%	PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKK	3
4	Y. RAJCHENBACH	2.500%	PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	4
5	A RAJCHENBACH	2.500%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO	PROGRESSIVE HEALTHCARE C	LINCOLNWOOD	NURSING	5
6	S BUSEL	2.500%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE				6
7	P SCHWARTZ	2.500%	THE GROVE OF EVANSTON,LLC	EVANSTON				7
8	JLR FAMILY TRUST	2.500%	THE GROVE OF LAGRANGE PARK,LLC	LAGRANGE PARK				8
9	R SHABAT	12.500%	WINDSOR PARK	CHICAGO				9
10	I WEISS	10.000%	CHALET LIVING	CHICAGO				10
11	ZVI FEINER	2.000%	THE GROVE AT THE LAKE	ZION				11
12	C FEINER	4.000%	THE GROVE OF NORTHBROOK	NORTHBROOK				12
13	A FEINER	4.000%						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

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

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	Demetrios Kouzious	Administrator	Administrative	5.00%	None	40	100.00%	Salary	\$ 196,319	17-01	1
2	Chaim Rajchenbach	Owner	Administrative	25.00%	See Attached	2	4.00%	Mgmt. Fees	8,000	17-07	2
3	Menachem Shabat	Owner	Administrative	25.00%	See Attached	2	4.00%	Mgmt. Fees	8,000	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 212,319		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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

Ending: 12/31/12

(847) 679-1126

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Legacy Real Properties
Street Address 7040 N. Ridgeway
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-1126

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	30	DEPRECIATION	AVAIL. BED DAYS	716,018	13	25,098		65,880	2,309	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	716,018	13	45,486		65,880	4,185	2
3	33	REAL ESTATE TAXES	AVAIL. BED DAYS	716,018	13	44,250		65,880	4,071	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					\$ 114,834	\$		\$ 10,565	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization	<u>Progressive Healthcare Consulting</u>
Street Address	<u>7040 N. Ridgeway</u>
City / State / Zip Code	<u>Lincolnwood, IL 60712</u>
Phone Number	<u>(847) 679-9797</u>
Fax Number	<u>(847) 679-1126</u>

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	498,858	9	\$	\$	65,880	\$	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	498,858	9			65,880		2
3	10	RN SALARY	AVAIL. BED DAYS	498,858	9	88,262	88,262	65,880	11,656	3
4	12	CELRGY SALARY	AVAIL. BED DAYS	498,858	9	18,263	18,263	65,880	2,412	4
5	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	498,858	9	11,955		65,880	1,579	5
6	17	ADMIN	AVAIL. BED DAYS	498,858	9	186,212	186,212	65,880	24,591	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	498,858	9	1,215		65,880	160	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	498,858	9			65,880		8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	498,858	9	2,058		65,880	272	9
10	24	SEMINARS	AVAIL. BED DAYS	498,858	9			65,880		10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	498,858	9			65,880		11
12	26	INSURANCE	AVAIL. BED DAYS	498,858	9			65,880		12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	498,858	9			65,880		13
14	30	DEPRECIATION	AVAIL. BED DAYS	498,858	9			65,880		14
15	32	INTEREST	AVAIL. BED DAYS	498,858	9			65,880		15
16	33	REAL ESTATE TAX	AVAIL. BED DAYS	498,858	9			65,880		16
17	34	RENT	AVAIL. BED DAYS	498,858	9			65,880		17
18	35	AUTO RENTAL	AVAIL. BED DAYS	498,858	9	999		65,880	132	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 308,964	\$ 292,737		\$ 40,802	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

VIII. ALLOCATION OF INDIRECT COSTS

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

Fax Number

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

Ending: 12/31/12**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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	Greystone		X	Mortgage Note			\$	13,771,228			\$	445,417	1
2	Seller Note		X									190,743	2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	HUD Note		X									108,926	6
7	IPFS		X	Working Capital/Liab. Insurance								2,054	7
8	See Supplemental Schedule											51,478	8
9	TOTAL Facility Related						\$	13,771,228			\$	798,618	9
	B. Non-Facility Related*												
10	Interest Income		X									(796)	10
11	Bldg. Co. - Interest Income		X									(7,482)	11
12	Allocated from Legacy Healthcare Financial Services											5	12
13	See Supplemental Schedule											4,185	13
14	TOTAL Non-Facility Related						\$				\$	(4,088)	14
15	TOTALS (line 9+line14)						\$	13,771,228			\$	794,530	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 46,100 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							\$	\$			\$		1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8	Private Bank		X	Line of Credit			\$	\$			\$	50,678	8
9	Diamond Insurance		X	Working capital/Workers com insurance								800	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital											51,478	14
	B. Non-Facility Related*												
15	Allocated from Legacy Real Properties						\$	\$			\$	4,185	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related											4,185	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	61,967	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.)		\$	67,505	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	5,538	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,262	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.		\$	65,800	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008		9	
		2009		10	
		2010	57,682	11	
		2011	63,434	12	
2012 Accrual = \$63,434 x .95 = \$60,262					
Allocated from Legacy Real Properties = \$4,071					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Elmbrook Nursing	COUNTY	Dupage
---------------	------------------	--------	--------

FACILITY IDPH LICENSE NUMBER 0051177

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 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	03-26-207-022	Long Term Care Facility	\$ 4,990.88	\$ 4,990.88
2.	03-26-207-025	Long Term Care Facility	\$ 58,441.84	\$ 58,441.84
3.	See Attached	See Attached	\$ 42,154.05	\$ 3,878.55
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 105,586.77	\$ 67,311.27

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmbrook Nursing COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051177

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 2000 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 2000.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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? YES NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

44,800

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>67,000</u>	<u>2010</u>	<u>\$ 606,331</u>	<u>1</u>
2	<u>Allocated from Legacy Real Properties</u>			<u>7,527</u>	<u>2</u>
3	TOTALS	67,000		\$ 613,858	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180		2010	1977	\$ 7,403,102	\$ 132,829	35	\$ 211,517	\$ 78,688	\$ 426,409	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)		51,634			(51,634)		67
68	Related Party Allocations (Pages 12H & 12I)	118,450	1,747		4,850	3,103	13,928	68
69	Financial Statement Depreciation		436,172			(436,172)		69
70	TOTAL (lines 4 thru 69)	\$ 7,521,552	\$ 622,382		\$ 216,367	\$ (406,015)	\$ 440,337	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmbrook Nursing

0051177

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 7,521,552	\$ 622,382		\$ 216,367	\$ (406,015)	\$ 440,337	1
2	Sprinklers - Systems Piping #2354	2011	6,826		20	171	171	341	2
3	Remodeling- Demolish Walls, New Walls, Paint	2011	4,650		20	116	116	233	3
4	3Rd Floor Bathrooms - Plumbing, Paint, Tile	2011	7,680		20	384	384	768	4
5	Replace Compressor On Air Conditioning Unit	2011	20,565		20	1,028	1,028	2,057	5
6	Replace Lining For Cooling Tower	2011	3,960		20	198	198	396	6
7	New Phone System	2011	6,440		20	322	322	644	7
8	Resident Rooms - Built In Furniture/Drywall/Wallpaper/Paint/Bas	2011	74,419		20	3,721	3,721	7,442	8
9	Sliding Door/Entrance	2011	5,123		20	256	256	512	9
10	Interior Signage	2011	9,825		20	491	491	982	10
11	Exterior Signage	2011	13,270		20	664	664	1,327	11
12	Electrical - Phone Jack Intallation/Low Voltage/Duplex Outlets	2011	56,290		20	2,815	2,815	5,629	12
13	Land Improvements - Paint Fence, Paving	2011	52,484		20	2,624	2,624	5,248	13
14	Project A - Lobby - Tiling/Crown Molding/Window/Wall Covering	2011	31,193		20	1,560	1,560	3,119	14
15	Project B - 1St Floor Cooridor - Handrails/Flooring/Tiling/Wallpa	2011	103,292		20	5,165	5,165	10,329	15
16	Project C - 1St Floor Resident Rooms - New Fixtures/Built In Hea	2011	29,734		20	1,487	1,487	2,973	16
17	Project D - 2Nd Floor Resident Rooms - Light Fixtures/Headboard	2011	57,548		20	2,877	2,877	5,755	17
18	Project E - 2Nd Floor Therapy Rooms - Dividing Wall/Wallpaper/	2011	40,936		20	2,047	2,047	4,094	18
19	Project F - 2Nd Floor Therapy Bathrooms - Flooring/Fixtures	2011	5,709		20	285	285	571	19
20	Project G - 3Rd Floor Resident Rooms - Light Fixtures/Paint/Win	2011	25,239		20	1,262	1,262	2,524	20
21	Project H - Front Offices - Flooring/Paint/Window	2011	17,943		20	897	897	1,794	21
22	Project I - Elevator - Cab Systems	2011	15,108		20	755	755	1,511	22
23	Project J - 1St Floor Nurses Station - Charting Unit/Railing/Tiling	2011	13,307		20	665	665	1,331	23
24	Project K - Resident Bathrooms - Flooring/Painting	2011	8,315		20	416	416	832	24
25	Project L - 2Nd Floor Nurses Station - Nurses Station/Charting Ur	2011	11,652		20	583	583	1,165	25
26	Project M - 2Nd Floor Dining Room - Flooring/Wallcovering/Wine	2011	24,849		20	1,242	1,242	2,485	26
27	Project N - 3Rd Floor Nurses Station - Nurses Station/Charting Ur	2011	11,652		20	583	583	1,165	27
28	Project O - 3Rd Floor Corridor - Flooring/Cove Base	2011	33,005		20	1,650	1,650	3,300	28
29	Project P - 3Rd Floor Dining Room - Flooring/Molding/Wallpaper	2011	36,984		20	1,849	1,849	3,698	29
30	Project Q - 2Nd Floor Corridor - Tiling/Flooring/Crown Molding/	2011	65,334		20	3,267	3,267	6,533	30
31	Wallpaper, Drywall, Paint	2011	2,800		20	140	140	280	31
32	Air Conditioning Unit	2011	4,250		20	213	213	425	32
33	Corner Guards, Lighting, Signage, Wallpaper	2011	4,176		20	209	209	418	33
34	TOTAL (lines 1 thru 33)		\$ 8,326,110	\$ 622,382		\$ 256,308	\$ (366,074)	\$ 520,219	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmbrook Nursing

0051177

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,326,110	\$ 622,382		\$ 256,308	\$ (366,074)	\$ 520,219	1
2	Wallpaper, Paint, Locks, Power Outlets	2011	5,325		20	266	266	533	2
3	Wallpaper, Paint, Baseboards	2011	5,100		20	255	255	510	3
4	Exterior Caulking	2011	5,500		20				4
5	Front Entrance - Fix Damaged Floor, Paint	2011	2,950		20				5
6	Air Handler Repair	2011	2,609		20				6
7	Demolish And Renovate Basement Room/Drywall/Paint/Electric/F	2011	5,750		20				7
8	Demolition: Remove All Damaged Drywall. Rough Carpentry: Re	2012	36,875		20	922	922	922	8
9	Wallcovering Supply 120 Yrds - Retreat Glacier, Wallcovering Su	2012	4,210		20	88	88	88	9
10	Water Based Adhesive And A 60Mil Sinfle Ply Ib Decking Shield.	2012	14,560		20	61	61	61	10
11	26 Door Locks, Renovate Basement Staff Bathroom And Build Ne	2012	8,625		20	72	72	72	11
12	Staff Office Repair: Build New Partion Wall, Remove Wall By Sto	2012	11,850		20	99	99	99	12
13	Add 4"-6" Of Compacted Rock Base, Install New Patio Of Hollan	2012	4,025		20	17	17	17	13
14	Replace 68 Lavatory Faucets, Install All New Water Supply Hoses	2012	10,200		20	170	170	170	14
15	Hot Water Boiler Replacement.	2012	12,900		20	591	591	591	15
16	Trane Twin Screw Chiller Unit.	2012	104,726		20	4,364	4,364	4,364	16
17	Fan Belt, Electrical Damper Motor, Commercial Service Call, Hel	2012	3,926		20	82	82	82	17
18	6 Gaskets,	2012	4,440		20	111	111	111	18
19	Hose, Valve, Belt, Soil, Ect.....	2012	2,796		20	47	47	47	19
20	Elevator Ceiling, New Lighting System.	2012	3,716		20	170	170	170	20
21	New Tiles	2012	7,050		20	206	206	206	21
22	Railing Bars For The Existing Stairwaus, Additional Bars.	2012	6,950		20	174	174	174	22
23	Corridor Repair, Cubicle Curtains, Sinage & Installation	2012	6,153		20	308	308	308	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)		\$ 8,596,346	\$ 622,382		\$ 264,311	\$ (358,071)	\$ 528,743	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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 12C, Carried Forward		\$ 8,596,346	\$ 622,382		\$ 264,311	\$ (358,071)	\$ 528,743	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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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)		\$ 8,596,346	\$ 622,382		\$ 264,311	\$ (358,071)	\$ 528,743	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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 12D, Carried Forward		\$8,596,346	\$622,382		\$264,311	\$(358,071)	\$528,743	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	TOTAL (lines 1 thru 33)		\$8,596,346	\$622,382		\$264,311	\$(358,071)	\$528,743	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13	Additional Depreciation			51,634			(51,634)		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

SEE ACCOUNTANTS' COMPILATION REPORT

**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		\$	\$		\$	\$	\$	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
TOTAL (12F & 12G lines 1 thru 33)			51,634			(51,634)		

SEE ACCOUNTANTS' COMPILATION REPORT

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

****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	Related Party Information Continued								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	TOTAL (12H & 12I lines 1 thru 33)		\$118,450	\$1,747		\$4,850	\$3,103	\$13,928	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$2,692,561	\$2,293	\$457,906	\$455,613	10	\$1,023,538	71
72	Current Year Purchases	19,625	417	1,436	1,019	10	1,436	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,712,186	\$2,710	\$459,342	\$456,632		\$1,024,973	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	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)	\$11,922,390	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$625,092	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$723,653	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$98,561	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,553,717	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	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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	Storage Unit				3,319			6
7	TOTAL				\$ 3,319			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

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: \$ 4,594
- Description: See Attached Schedule

(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	Allocated from Progressive Healthcare Consulting		\$	\$ 132	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 132	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

In the box below record the amount of income your facility received training CNAs from other facilities.	
\$	

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	39 - 03	hrs	\$		\$ 472,652	\$		\$ 472,652	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			111,096			111,096	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			642,584			642,584	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				422,070		422,070	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					41,568	62,235		103,803	13
14	TOTAL			\$		\$ 1,267,900	\$ 484,305		\$ 1,752,205	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	\$ 1,233,060	1
2	Cash-Patient Deposits	10,599	10,599	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,419,095	3,419,095	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	179,541	179,541	6
7	Other Prepaid Expenses	122,825	180,324	7
8	Accounts Receivable (owners or related parties)	1,249	1,249	8
9	Other(specify): See Attached Schedule	104,445	438,901	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,837,754	\$ 5,462,769	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,309,500	13
14	Buildings, at Historical Cost		5,180,335	14
15	Leasehold Improvements, at Historical Cost	307,764	977,895	15
16	Equipment, at Historical Cost	1,888,510	1,903,510	16
17	Accumulated Depreciation (book methods)	(569,345)	(960,364)	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): See Attached Schedule	3,690,000	3,770,896	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,316,929	\$ 12,181,772	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,154,683	\$ 17,644,541	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,077,942	\$ 1,077,942	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	606,320	606,320	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,451	64,451	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,403	60,262	32
33	Accrued Interest Payable		30,182	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	777,357	131,411	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,570,473	\$ 1,970,568	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,771,228	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 13,771,228	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,570,473	\$ 15,741,796	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,584,210	\$ 1,902,745	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,154,683	\$ 17,644,541	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,490,286	1
2	Restatements (describe):		2
3	Prior Period Revenue adj	435,489	3
4	Prior Period Medicaid Tax	(123,525)	4
5	Prior Period:Depreciation, Loss on sale of Assets, Bad debt, Mana	(682,728)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,119,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,614,688	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	(1,150,000)	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)	\$ 464,688	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)	\$ 6,584,210	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$11,775,813	1
2	Discounts and Allowances for all Levels	(226,625)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$11,549,188	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,602,833	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$2,602,833	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	322,274	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	62,482	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$384,756	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	796	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$796	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	9,660	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$9,660	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$14,547,233	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,579,527	31
32	Health Care	4,117,997	32
33	General Administration	2,365,998	33
	B. Capital Expense		
34	Ownership	1,996,014	34
	C. Ancillary Expense		
35	Special Cost Centers	2,485,091	35
36	Provider Participation Fee	387,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$12,932,545	40
41	Income before Income Taxes (line 30 minus line 40)**	1,614,688	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$1,614,688	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$6,278,376	44
45	Private Pay - Net Inpatient Revenue	906,294	45
46	Medicare - Net Inpatient Revenue	4,101,021	46
47	Other-(specify) Veteran	169,693	47
48	Other-(specify) Insurance	93,804	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$11,549,188	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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	1,673	1,772	\$ 81,308	\$ 45.88	1
2	Assistant Director of Nursing	1,946	2,035	78,966	38.80	2
3	Registered Nurses	40,050	43,064	1,221,837	28.37	3
4	Licensed Practical Nurses	20,050	21,239	512,527	24.13	4
5	CNAs & Orderlies	97,014	104,011	1,314,186	12.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,523	10,700	202,309	18.91	8
9	Activity Director	1,954	2,091	40,879	19.55	9
10	Activity Assistants	8,962	9,848	157,637	16.01	10
11	Social Service Workers	3,803	4,095	55,057	13.44	11
12	Dietician					12
13	Food Service Supervisor	1,914	2,091	53,566	25.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,897	27,986	298,914	10.68	15
16	Dishwashers					16
17	Maintenance Workers	3,848	4,335	104,821	24.18	17
18	Housekeepers	19,307	20,852	261,799	12.56	18
19	Laundry	4,877	5,376	68,566	12.75	19
20	Administrator	3,897	4,125	302,029	73.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,019	10,547	132,799	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	619	676	20,712	30.64	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,445	1,554	28,504	18.34	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,905	2,035	53,729	26.40	33
34	TOTAL (lines 1 - 33)	258,703	278,432	\$ 4,990,145 *	\$ 17.92	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	370	\$ 16,574	01-03	35
36	Medical Director	Monthly	39,050	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,080	27,360	10-03	38
39	Pharmacist Consultant	Monthly	8,722	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	11	664	12-03	45
46	Other(specify)				46
47	Clergy	Per visit	50	12-03	47
48	MDS Consulting	Monthly	48,000	10-03	48
49	TOTAL (lines 35 - 48)	1,461	\$ 140,420		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Demetrios Kouzios	Administrator	5.00%	\$ 196,319
Abraham Mathew	Administrator	0.00%	105,711
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 302,030
B. Administrative - Other			
Description			Amount
Legacy Healthcare - Management Fees			\$ 16,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 16,000
C. Professional Services			
Vendor/Payee	Type		Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 30,668
Krupnick, Bokor, Kagda & Brooks	Accounting		925
Accu-Med Services	Computer Services		6,840
Health Data System, Inc.	Data Processing		10,882
Nebo Systems Inc	Computer Consulting		1,177
Linda Smith	Long Term Care Consultant		3,369
Innovative Therapy Partners	Compliance Audit		2,125
IIT/Sourcetek	Data Processing		1,135
ML Enterprises	Purchasing Consultant		4,200
Personnel Planners	Unemployment Consulting		1,644
Legal	See Attached		38,716
See Supplemental Schedule			268,118
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 369,799
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 136,282
Unemployment Compensation Insurance			99,172
FICA Taxes			360,733
Employee Health Insurance			123,368
Employee Meals			46,907
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension			53,153
Employee Benefits Other			12,613
Employee Physical Exam			5,768
TOTAL (agree to Schedule V, line 22, col.8)			\$ 837,996
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			8,185
Health Care Worker Background Check (Indicate # of checks performed)	728		7,280
Patient Background Checks			
Dues & Subscriptions			11,807
Licenses & Fees			3,740
Alloc. From Legacy Real Properties			
Alloc. From Legacy Healthcare Fin. Serv.			58
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 31,070
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,259
Alloc. From Legacy Healthcare Fin. Serv.			202
Entertainment Expense	(		)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 1,461

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ILCLTC \$8,167.50

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

Yes

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

Yes

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

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

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

\$62,084

Line10

(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?

YESXNO

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

YESNOX

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.

\$386,763

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.

\$46,907

Has any meal income been offset against related costs?

No

Indicate the amount.

\$N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% ln 14

d. Have vehicle usage logs been maintained?

No

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?

Yes

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

No

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

\$N/A

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

No

Firm Name:

N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' COMPILATION REPORT