

		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: 0003038 Facility Name: Elmhurst Extended Care Center Address: 200 East Lake Street Elmhurst 60126 County: Dupage Telephone Number: 630-516-5000 Fax #: 630-834-0480 HFS ID Number: Date of Initial License for Current Owners: 02/18/1961 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code x PROPRIETARY Individual Partnership Corporation x "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: Rob Schlicht Telephone Number: 414-431-9335 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) (Type or Print Name) John Massard (Title) Administrator Paid Preparer (Signed) (Print Name and Title) Rob Schlicht Director (Firm Name & Address) Wipfli LLP 10000 Innovation Drive, Suite 250, Milwaukee WI 53226 (Telephone) 414-431-9335 Fax #: 414-431-9303 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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Facility Name & ID Number Elmhurst Extended Care Center# 0003038 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 _____

	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>108</u>	Skilled (SNF)	<u>108</u>	<u>39,420</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>108</u>	TOTALS	<u>108</u>	<u>39,420</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>4,126</u>	<u>18,250</u>	<u>6,254</u>	<u>28,630</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>4,126</u>	<u>18,250</u>	<u>6,254</u>	<u>28,630</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 72.63%

D. How many bed-hold days during this year were paid by the Department?

(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)F. Does the facility maintain a daily midnight census? YesG. 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 08/09/1960

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 112 and days of care provided 6,254Medicare 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.

	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	275,243	41,082		316,325		316,325		316,325			1
2	Food Purchase		180,776		180,776		180,776		180,776			2
3	Housekeeping		32,764		32,764		32,764		32,764			3
4	Laundry	29,293	16,104	(603)	44,794		44,794		44,794			4
5	Heat and Other Utilities			101,062	101,062		101,062		101,062			5
6	Maintenance	208,168		106,303	314,471		314,471		314,471			6
7	Other (specify):*											7
8	TOTAL General Services	512,704	270,726	206,762	990,192		990,192		990,192			8
	B. Health Care and Programs											
9	Medical Director			30,825	30,825		30,825		30,825			9
10	Nursing and Medical Records	2,087,733	100,495	226,353	2,414,581		2,414,581	(28,814)	2,385,767			10
10a	Therapy	54,880	5,942	134,811	195,633		195,633		195,633			10a
11	Activities	106,913	191	1,457	108,561		108,561		108,561			11
12	Social Services	64,952		280	65,232		65,232		65,232			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,314,478	106,628	393,726	2,814,832		2,814,832	(28,814)	2,786,018			16
	C. General Administration											
17	Administrative	106,049			106,049		106,049		106,049			17
18	Directors Fees											18
19	Professional Services			32,866	32,866		32,866		32,866			19
20	Dues, Fees, Subscriptions & Promotions			37,544	37,544		37,544	(29,206)	8,338			20
21	Clerical & General Office Expenses	320,817	8,365	150,433	479,615		479,615	(8,038)	471,577			21
22	Employee Benefits & Payroll Taxes			534,705	534,705		534,705	(4,702)	530,003			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,918	11,918		11,918		11,918			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,025	70,025		70,025		70,025			26
27	Other (specify):*											27
28	TOTAL General Administration	426,866	8,365	837,491	1,272,722		1,272,722	(41,946)	1,230,776			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,254,048	385,719	1,437,979	5,077,746		5,077,746	(70,760)	5,006,986			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			129,603	129,603		129,603	47,802	177,405			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			48,806	48,806		48,806		48,806			33
34	Rent-Facility & Grounds			1,584	1,584		1,584		1,584			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			179,993	179,993		179,993	47,802	227,795			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	244,106	257,836	18,604	520,546		520,546		520,546			39
40	Barber and Beauty Shops			15,417	15,417		15,417	(15,417)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,103	215,103		215,103		215,103			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	244,106	257,836	249,124	751,066		751,066	(15,417)	735,649			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,498,154	643,555	1,867,096	6,008,805		6,008,805	(38,375)	5,970,430			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	47,802	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,636)	21		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	(4,702)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,865)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(20,341)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 6,258		\$	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)			34
35	Other- Attach Schedule	(44,633)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (44,633)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (38,375)		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

ID# 0003038
Report Period Beginning: 01/01/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Comfort Item Revenue	\$ (28,814)	10	1
2	Miscellaneous Revenue	(208)	21	2
3	Bank Charges	(194)	21	3
4	Barber and beauty	(15,417)	40	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	(44,633)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmhurst Extended Care Center

0003038

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(28,814)	0	0	0	0	0	0	0	0	0	0	(28,814)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(28,814)	0	0	0	0	0	0	0	0	0	0	(28,814)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(29,206)	0	0	0	0	0	0	0	0	0	0	(29,206)	20
21	Clerical & General Office Expenses	(8,038)	0	0	0	0	0	0	0	0	0	0	(8,038)	21
22	Employee Benefits & Payroll Taxes	(4,702)	0	0	0	0	0	0	0	0	0	0	(4,702)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(41,946)	0	0	0	0	0	0	0	0	0	0	(41,946)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(70,760)	0	0	0	0	0	0	0	0	0	0	(70,760)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	47,802	0	0	0	0	0	0	0	0	0	0	47,802	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	47,802	0	0	0	0	0	0	0	0	0	0	47,802	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(15,417)	0	0	0	0	0	0	0	0	0	0	(15,417)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(15,417)	0	0	0	0	0	0	0	0	0	0	(15,417)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(38,375)	0	0	0	0	0	0	0	0	0	0	(38,375)	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
John Massard	100			n/a		

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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	John Massard	Owner	Administrator	100.00	none	40	100.00	Salary	\$ 106,049	17-1	1
2	Peggy Massard	Relative	Secretary/Bookpr		none	40	100.00	Salary	43,205	21-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 149,254		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 Elmhurst Extended Care Center # 0003038 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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	44,051	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.)			\$	48,806	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,755	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	44,051	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.			\$	48,806	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007 40,565 8			
		2008 39,167 9			
		2009 40,689 10			
		2010 43,259 11			
		2011 44,051 12			
			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
Elmhurst Extended Care Center

COUNTY
Dupage

FACILITY IDPH LICENSE NUMBER
0003038

CONTACT PERSON REGARDING THIS REPORT
Rob Schlicht

TELEPHONE
414-431-9335
FAX #
414-431-9303

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 03-36-30-029	Long term care property	\$ 48,806.00	\$ 48,806.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 48,806.00	\$ 48,806.00

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 x 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	33,019	B. General Construction Type:	Exterior	brick	Frame	Number of Stories	2
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	--------------------------	----------

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).

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	Resident Care	41,851	1961	\$ 92,016	1
2	parking lot			6,950	2
3	TOTALS	41,851		\$ 98,966	3

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	39		1961	1961	\$ 122,779	\$	40	\$	\$	\$ 122,779	4
5	73		1976	1976	1,174,345		40	29,359	29,359	1,086,283	5
6			1980	1980	46,390		40	1,160	1,160	37,120	6
7			1998	1998	700		40			700	7
8			1998	1998	43,075		40	1,077	1,077	39,490	8
	Improvement Type**										
9	Various		1983		7,336		20			7,336	9
10	Various		1984		5,800		20			5,800	10
11	Various		1987		1,630		20			1,630	11
12	Various		1989		7,744		20			7,744	12
13	Various		1995		4,900		20	245	245	4,410	13
14	Various		1996		4,960		20	248	248	4,316	14
15	Various		1998		6,800		20	340	340	5,100	15
16	Various		1999		12,875		20	644	644	9,013	16
17	Various		2000		2,439		20	122	122	1,586	17
18	Various		2001		4,340		20	217	217	2,604	18
19	Various		2002		20,290		20	1,015	1,015	11,161	19
20	Various		2003		1,980		20	99	99	990	20
21	Various		2004		156,262		20	7,813	7,813	70,318	21
22	Various		2005		141,628		20	7,081	7,081	56,650	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

See Page 12A, Line 70 for total

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	
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									67
68									68
69	Financial Statement Depreciation			129,603			(129,603)		69
70	TOTAL (lines 4 thru 69)		\$ 1,766,273	\$ 129,603		\$ 49,420	\$ (80,183)	\$ 1,475,030	70

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

Facility Name & ID Number Elmhurst Extended Care Center

0003038

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 12A, Carried Forward		\$ 1,766,273	\$ 129,603		\$ 49,420	\$ (80,183)	\$ 1,475,030	1
2	Tile 1w	2006	7,318		20	366	366	2,562	2
3	Light Fixtures	2006	2,515		20	126	126	881	3
4	Call light system 1w	2006	12,134		20	607	607	4,248	4
5	Nurses station remodel 1w	2006	4,738		20	237	237	1,659	5
6	Dining room renovation	2006	11,055		20	553	553	3,870	6
7	Concrete work	2006	22,970		20	1,149	1,149	6,893	7
8	Steel fire door	2006	3,991		20	200	200	1,199	8
9	Wallcovering	2007	13,066		20	653	653	3,919	9
10	Painting	2007	14,843		20	742	742	4,452	10
11	Tile	2007	6,453		20	323	323	1,937	11
12	Generator	2007	6,789		20	339	339	1,985	12
13	Pavement improvement	2007	2,160		20	108	108	464	13
14	Saw and patch floor	2007	21,279		20	1,064	1,064	5,320	14
15	Catch basin plumb work	2007	11,109		20	555	555	2,776	15
16	Underground conduits	2007	6,560		20	328	328	1,640	16
17	Emergency fire alarm	2007	19,292		20	965	965	4,824	17
18	Concrete placement	2008	3,000		20	150	150	650	18
19	Boiler	2008	15,525		20	776	776	2,974	19
20	Countertop	2008	1,127		20	56	56	244	20
21	Door holding wiring	2008	5,906		20	295	295	1,476	21
22	Drain line	2008	48,367		20	2,418	2,418	12,091	22
23	Install ceiling fan cooling unit	2008	7,800		20	390	390	1,560	23
24	Drapery	2008	3,740		20	187	187	748	24
25	Drapery	2008	3,152		20	158	158	632	25
26	Fan coil units	2008	11,219		20	561	561	2,244	26
27	TV cable upgrades	2008	6,000		20	300	300	1,200	27
28	Elevator bolster cable channels	2008	2,947		20	147	147	588	28
29	Elevator cylinders raplacement	2008	17,781		20	889	889	3,556	29
30	Fill in hole, install top soil, re-sod, repair bricks	2008	9,840		20	492	492	1,968	30
31	Painting	2008	906		20	45	45	180	31
32	Wallcovering	2008	909		20	45	45	180	32
33	Carpets	2008	3,018		20	151	151	604	33
34	TOTAL (lines 1 thru 33)		\$ 2,073,782	\$ 129,603		\$ 64,795	\$ (64,808)	\$ 1,554,554	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 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		\$ 2,073,782	\$ 129,603		\$ 64,795	\$ (64,808)	\$ 1,554,554	1
2	Fire alarm repairs	2008	3,927		20	196	196	784	2
3	Basement iron pipe repair	2008	3,685		20	184	184	736	3
4	Replace cast iron piping and hangars	2009	4,624		20	231	231	924	4
5	Replace elevator rail brackets	2009	4,958		20	248	248	992	5
6	Replace patio	2009	5,350		20	268	268	1,072	6
7	Drapery	2009	3,545		20	177	177	708	7
8	2nd floor cabling	2009	6,000		20	300	300	1,200	8
9	Fire sprinkler system upgrades/repairs	2009	32,530		20	1,627	1,627	6,508	9
10	Replace drain tile outside south side of building	2009	83,841		20	4,192	4,192	16,768	10
11	Rod window wells	2009	3,075		20	154	154	616	11
12	Plumbing repairs in main exterior drains	2009	2,732		20	137	137	548	12
13	Painting	2009	3,273		20	164	164	656	13
14	Painting	2009	28,875		20	1,444	1,444	5,776	14
15	New Roof	2009	72,962		20	3,648	3,648	10,944	15
16	Streamline Painting	2010	17,289		20	864	864	2,592	16
17	Replace Basement hallway floor	2011	14,396		20	720	720	1,440	17
18	Replace basement office floor	2011	14,289		20	714	714	1,428	18
19	Add rooftop deck	2011	81,115		20	4,056	4,056	8,112	19
20	Replace west wing floor	2011	26,573		20	1,329	1,329	2,658	20
21	Replace front office flooring	2012	3,772		20	189	189	189	21
22	Replace east rooms and landing flooring	2012	50,713		20	2,536	2,536	2,536	22
23	Replace storage room and back hallway flooring	2012	4,785		20	239	239	239	23
24	Replace front office counter tops	2012	2,170		20	109	109	109	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)		\$ 2,548,261	\$ 129,603		\$ 88,519	\$ (41,084)	\$ 1,622,089	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	\$1,591,993	\$	\$59,482	\$59,482	10	\$1,001,646	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,591,993	\$	\$59,482	\$59,482		\$1,001,646	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		2007 lexus	2006	\$28,823	\$	\$3,185	\$3,185	5	\$28,823	76
77		Auto	2006	12,868				5	12,868	77
78		2010 Ford Bu	2010	69,207		13,841	13,841	5	41,523	78
79		2010 GMC Yukon	2010	61,885		12,377	12,377	5	37,131	79
80	TOTALS			\$172,783	\$	\$29,403	\$29,403		\$120,345	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,412,003	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$129,603	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$177,405	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$47,802	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,744,080	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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Office storage rental				1,584			5
6								6
7	TOTAL				\$1,584			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: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

ALLOCATION OF COSTS (d)

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

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678											
	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	39-01	1181	hrs	\$ 51,837	1,799	\$ 83,125	\$	2,980	\$ 134,962	1
2	Licensed Speech and Language Development Therapist			hrs			12,480			12,480	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39-01	3808	hrs	186,085	626	25,500		4,434	211,585	4
5	Physician Care	9-03		visits			30,225			30,225	5
6	Dental Care	9-03		visits			600			600	6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39-02		# of prescrpts				257,836		257,836	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				\$ 237,922	2,425	\$ 151,930	\$ 257,836	7,414	\$ 647,688	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	\$ 268,051	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	617,184		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,367		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	18,349		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 935,951	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,966		13
14	Buildings, at Historical Cost	1,503,046		14
15	Leasehold Improvements, at Historical Cost	804,173		15
16	Equipment, at Historical Cost	1,707,810		16
17	Accumulated Depreciation (book methods)	(3,444,461)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 669,534	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,605,485	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 108,321	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	336,496		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	154,384		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 599,201	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 599,201	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,006,284	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,605,485	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (258,804)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (258,804)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,265,088	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)	\$ 1,265,088	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)	\$ 1,006,284	24 *

* This must agree with page 17, line 47.

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,732,793	1
2	Discounts and Allowances for all Levels	(410,496)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,322,297	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,144,030	6
7	Oxygen	34,822	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,178,852	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	21,476	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	334,086	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,437	19
20	Radiology and X-Ray	8,973	20
21	Other Medical Services	396,046	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 770,018	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,044	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,044	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	(31,318)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (31,318)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,273,893	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	990,192	31
32	Health Care	2,814,832	32
33	General Administration	1,272,722	33
	B. Capital Expense		
34	Ownership	179,993	34
	C. Ancillary Expense		
35	Special Cost Centers	535,963	35
36	Provider Participation Fee	215,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,008,805	40
41	Income before Income Taxes (line 30 minus line 40)**	1,265,088	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,265,088	43

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

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,984	2,160	\$ 95,059	\$ 44.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,606	18,755	605,547	32.29	3
4	Licensed Practical Nurses	16,837	18,596	466,578	25.09	4
5	CNAs & Orderlies	68,119	74,359	920,549	12.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,570	6,182	106,913	17.29	10
11	Social Service Workers	1,904	2,080	64,952	31.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,318	17,915	275,243	15.36	15
16	Dishwashers					16
17	Maintenance Workers	13,727	14,977	208,168	13.90	17
18	Housekeepers					18
19	Laundry	1,966	2,176	29,293	13.46	19
20	Administrator	1,864	2,080	106,049	50.99	20
21	Assistant Administrator					21
22	Other Administrative	11,190	12,016	320,817	26.70	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	7,117	7,317	298,986	40.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,202	178,613	\$ 3,498,154 *	\$ 19.59	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		\$		35
36	Medical Director	monthly	30,225	9-03	36
37	Medical Records Consultant	24	1,440	09-03	37
38	Nurse Consultant	daily	59,076	09-03	38
39	Pharmacist Consultant	monthly	2,391	09-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,052	11-03	44
45	Social Service Consultant	4	280	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	44	\$ 94,464		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

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

** 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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

Life Services Network \$3530

(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

(6)

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

\$ 26,862

Line

10-03

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

n/a

(9)

Are you presently operating under a sublease agreement?

YES

x

NO

(10)

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

YES

NO

x

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 215,103

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.

\$ 0

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?

none

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?

no

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

yes

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

no

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

\$ n/a

(17)

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

no

Firm Name:

(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.