

		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: 0046128

Facility Name: Elmwood Terrace Healthcare Center

Address: 1017 West Galena Aurora 60506
Number City Zip Code

County: Kane

Telephone Number: 630-897-3100 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 02/18/03

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: Mendel S Schneider Telephone Number: 847-933-1274
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)	see Accountant's Report Attached		
	(Firm Name & Address)	Mendel S Schneider & Associates, CPA, PC 4556 Oakton St, Ste 200, Skokie, IL 60076		
	(Telephone)	847-933-1274	Fax #	847-933-1273
	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			

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128 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>68</u>	Skilled (SNF)	<u>68</u>	<u>24,888</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>68</u>	TOTALS	<u>68</u>	<u>24,888</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>1,780</u>	<u>56</u>	<u>3,357</u>	<u>5,193</u>	8
9	SNF/PED					9
10	ICF	<u>16,017</u>	<u>508</u>		<u>16,525</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,797</u>	<u>564</u>	<u>3,357</u>	<u>21,718</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.26%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

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 02/18/03

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

YES ☒Date 02/18/03NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 68 and days of care provided 3,357Medicare Intermediary Riverbend

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31Fiscal Year: 12/31

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	138,645	12,000	4,525	155,170		155,170		155,170		1
2	Food Purchase		151,256		151,256	(3,000)	148,256		148,256		2
3	Housekeeping	162,099	34,244	31,732	228,075		228,075		228,075		3
4	Laundry		2,403		2,403		2,403		2,403		4
5	Heat and Other Utilities			64,706	64,706		64,706		64,706		5
6	Maintenance	44,921		108,020	152,941		152,941		152,941		6
7	Other (specify):*										7
8	TOTAL General Services	345,665	199,903	208,983	754,551	(3,000)	751,551		751,551		8
	B. Health Care and Programs										
9	Medical Director			41,000	41,000		41,000		41,000		9
10	Nursing and Medical Records	1,160,004	122,611	18,000	1,300,615		1,300,615		1,300,615		10
10a	Therapy										10a
11	Activities	38,297	3,216		41,513		41,513		41,513		11
12	Social Services	41,760		1,239	42,999		42,999		42,999		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,240,061	125,827	60,239	1,426,127		1,426,127		1,426,127		16
	C. General Administration										
17	Administrative	94,235		42,000	136,235		136,235		136,235		17
18	Directors Fees										18
19	Professional Services			53,627	53,627		53,627	(17,072)	36,555		19
20	Dues, Fees, Subscriptions & Promotions			9,548	9,548		9,548	(5,516)	4,032		20
21	Clerical & General Office Expenses	59,866	46,471	48,787	155,124		155,124	(2,376)	152,748		21
22	Employee Benefits & Payroll Taxes			305,718	305,718	3,000	308,718		308,718		22
23	Inservice Training & Education										23
24	Travel and Seminar			22,710	22,710		22,710		22,710		24
25	Other Admin. Staff Transportation			8,373	8,373		8,373		8,373		25
26	Insurance-Prop.Liab.Malpractice			65,063	65,063		65,063		65,063		26
27	Other (specify):*										27
28	TOTAL General Administration	154,101	46,471	555,826	756,398	3,000	759,398	(24,964)	734,434		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,739,827	372,201	825,048	2,937,076		2,937,076	(24,964)	2,912,112		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			64,386	64,386		64,386	2,863	67,249			30
31	Amortization of Pre-Op. & Org.							13,134	13,134			31
32	Interest			62,212	62,212		62,212	86,506	148,718			32
33	Real Estate Taxes							51,990	51,990			33
34	Rent-Facility & Grounds			130,000	130,000		130,000	(130,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			256,598	256,598		256,598	24,493	281,091			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			145,360	145,360		145,360		145,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			145,360	145,360		145,360		145,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,739,827	372,201	1,227,006	3,339,034		3,339,034	(471)	3,338,563			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	(8,046)	30		9
10	Interest and Other Investment Income	(116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,072)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,516)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,011)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,191)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	32,720		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,720		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (471)		37

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

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

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

Elmwood Terrace Healthcare Center

Report Period Beginning: ID# 0046128

Ending: 01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	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	(17,072)	0	0	0	0	0	0	0	0	0	0	(17,072)	19
20	Fees, Subscriptions & Promotions	(5,516)	0	0	0	0	0	0	0	0	0	0	(5,516)	20
21	Clerical & General Office Expenses	(2,441)	65	0	0	0	0	0	0	0	0	0	(2,376)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(25,029)	65	0	0	0	0	0	0	0	0	0	(24,964)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(25,029)	65	0	0	0	0	0	0	0	0	0	(24,964)	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	(8,046)	10,909	0	0	0	0	0	0	0	0	0	2,863	30
31	Amortization of Pre-Op. & Org.	0	13,134	0	0	0	0	0	0	0	0	0	13,134	31
32	Interest	(116)	86,622	0	0	0	0	0	0	0	0	0	86,506	32
33	Real Estate Taxes	0	51,990	0	0	0	0	0	0	0	0	0	51,990	33
34	Rent-Facility & Grounds	0	(130,000)	0	0	0	0	0	0	0	0	0	(130,000)	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	(8,162)	32,655	0	0	0	0	0	0	0	0	0	24,493	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(33,191)	32,720	0	0	0	0	0	0	0	0	0	(471)	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
Ari Haas	40			Elmwood LLC	Aurora	Bldg Rental
David Abell	30					
Joseph Brandman	30					

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	Rent	\$ 130,000	Elmwood Terrace, LLC	100.00%	\$	(130,000)	1
2	V	32	Interest				86,622	86,622	2
3	V	33	Real Estate Tax				51,990	51,990	3
4	V	30	Depreciation				10,909	10,909	4
5	V	31	Amortization				13,134	13,134	5
6	V	21	Office				65	65	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 130,000			\$ 162,720	\$ * 32,720	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	David Abell		Management	30.00		20	50.00	Management	\$ 21,000	17-3	1
2	Joseph Brandman		Management	30.00		20	50.00	Management	21,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,000		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 Elmwood Terrace Healthcare Center # 0046128 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	First Equity Bank		X	Mortgage	\$7,968.51	3/15/04	\$ 1,200,000	\$		8.2500	\$ 37,590	1	
2	MB Financial		X	Mortgage	\$22,000.00	09/06/12	8,150,000	8,150,000	09/05/14	4.2500	49,031	2	
3												3	
4												4	
5												5	
	Working Capital												
6	MB Financial		X	Working Capital		11/20/08	450,000	890,000	06/05/13	4.2500	52,868	6	
7	Marvin Wolfe		X	Working Capital		06/01/12	400,000			6.5000	9,345	7	
8												8	
9	TOTAL Facility Related				\$29,968.51		\$ 10,200,000	\$ 9,040,000			\$ 148,834	9	
	B. Non-Facility Related*												
10	Interest Income										(116)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (116)	14	
15	TOTALS (line 9+line14)						\$ 10,200,000	\$ 9,040,000			\$ 148,718	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.		\$	38,320	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.)				\$	44,708	2
3. Under or (over) accrual (line 2 minus line 1).				\$	6,388	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	45,602	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.				\$	51,990	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2007	31,177	8		
		2008	31,438	9		
		2009	34,900	10		
		2010	34,651	11		
		2011	37,596	12		
44708 x 1.02						

	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
Elmwood Terrace Healthcare Center

COUNTY
Kane

FACILITY IDPH LICENSE NUMBER
0046128

CONTACT PERSON REGARDING THIS REPORT
David Abell

TELEPHONE
773-338-4400

FAX #:
773-338-4414

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. 15-20-276-013		\$ 4,795.00	\$
2. 15-20-276-014		\$ 39,913.00	\$ 39,913.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 44,708.00	\$ 39,913.00

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:	15,481	B. General Construction Type:	Exterior Brick	Frame Brick	Number of Stories
------------------------	---------------	--------------------------------------	-----------------------	--------------------	--------------------------

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:	26,572 66,085	2. Number of Years Over Which it is Being Amortized:	15
---------------------------	---------------	--	----

3. Current Period Amortization:	13,134	4. Dates Incurred:	03/04 06/12
--	---------------	---------------------------	--------------------

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	Facility	14,166	2003	\$ 50,000	1
2					2
3	TOTALS	14,166		\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	68		2003		\$ 300,000	\$ 10,909	27.5	\$ 10,909		\$ 107,726
5										
6										
7										
8										
	Improvement Type**									
9	Paving		2005		11,969	435	27.5	435		3,208
10	Tiling		2005		3,895	142	27.5	142		1,083
11	Alarms		2005		9,818	357	27.5	357		2,782
12	Corridor Renovation		2010							
13	New Floor				37,224		27.5	1,354	1,354	4,062
14	Wallcovering				8,400		27.5	305	305	915
15	Hand Rails, Bumper Guards, and Corner Guards				21,479		27.5	781	781	2,343
16	Installation of Door Casings				10,125		27.5	368	368	1,104
17	Light Fixtures				9,880		27.5	359	359	1,077
18	Custom Signage				3,661		27.5	133	133	399
19	Resident Rooms Renovation		2010							
20	Remove Existing Cove Base and Install New Cove Base				38,334		27.5	1,394	1,394	4,182
21	Room Renovation				32,671		27.5	1,188	1,188	3,564
22	Bumper Guards				6,984		27.5	254	254	762
23	Cubicle Curtains				14,852		27.5	540	540	1,620
24	Head and Foot Boards				7,300		27.5	265	265	795
25	Window Treatments				10,531		27.5	383	383	1,149
26	Wall Scones				5,321		27.5	193	193	579
27	Light Fixtures				17,953		27.5	653	653	1,959
28	Bathroom Renovation		2010							
29	New Floor				10,185		27.5	370	370	1,110
30	Mirrirs				2,657		27.5	97	97	291
31	Lighting				3,408		27.5	124	124	372
32	Nurses Station Renovation				10,348		27.5	376	376	1,128
33	Dining Room Renovation		2010							
34	New floor				8,103		27.5	295	295	885
35	Wallcovering				2,053		27.5	75	75	225
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	Living Room Renovation	2010	\$	\$		\$	\$	\$	37
38	New Carpeting		1,859		27.5	68	68	204	38
39	Wallcovering		1,524		27.5	55	55	165	39
40	Window Treatments		699		27.5	25	25	75	40
41	Renovating Beauty Salon	2010							41
42	New floor		1,812		27.5	66	66	198	42
43	Wallcovering		1,415		27.5	51	51	153	43
44	Custom Cabinets		8,125		27.5	295	295	885	44
45	Lighting		1,354		27.5	49	49	147	45
46	Shampoo Station		1,950		27.5	71	71	213	46
47	Corridors, Business Office, Small Dining Room	2010							47
48	Main Dining Room, DON Office, Lounge								48
49	Painting and Wallcoverings		69,500		27.5	2,527	2,527	7,581	49
50	Install New Windows	2010	32,000		27.5	1,164	1,164	3,492	50
51	Install Dining Room Window Treatments	2010	743		27.5	27	27	81	51
52	Repaving Parking Lot	2010	39,550		27.5	1,438	1,438	4,314	52
53	Enlarge Therapy Room and Install New Flooring, Plumbing	2012							53
54	, Lighting, and Electrical, Install New Sliding Doors		356,721	17,836	15	11,891	(5,945)	11,891	54
55	Replace all Doorsand Install new lighting in resident rooms								55
56	New Nurses Station and Medication Room								56
57	New Bathroom in dialysis room,Build 2 new showers								57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,104,403	\$ 29,679		\$ 39,077	\$ 9,398	\$ 172,719	70

**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	\$236,725	\$616	\$23,672	\$23,056	10	\$156,368	71
72	Current Year Purchases	45,000	45,000	4,500	(40,500)	10	4,500	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$281,725	\$45,616	\$28,172	\$(17,444)		\$160,868	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,436,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$75,295	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$67,249	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(8,046)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$333,587	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.
- ☐ YES☐ NO

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

**

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)

		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.

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

HFS 3745 (N-4-99)

IL478-2471

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (98,879)	\$ 3,561,581	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,855,156	2,855,156	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,279	75,279	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Others	328,188	1,080,631	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,159,744	\$ 7,572,647	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost	236,700	536,700	14
15	Leasehold Improvements, at Historical Cost	953,217	953,217	15
16	Equipment, at Historical Cost	181,725	281,725	16
17	Accumulated Depreciation (book methods)	(737,343)	(945,069)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	159,399	252,056	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(117,399)	(144,338)	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)	\$ 676,299	\$ 984,291	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,836,043	\$ 8,556,938	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 310,382	\$ 310,382	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	890,000	890,000	29
30	Accrued Salaries Payable	15,207	15,207	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,949	10,949	31
32	Accrued Real Estate Taxes(Sch.IX-B)		45,602	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,406	14,406	35
	Other Current Liabilities(specify):			
36	Due to Others	109,272	109,272	36
37	Due to LLC	967,545		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,317,761	\$ 1,395,818	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,150,000	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)	\$	\$ 8,150,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,317,761	\$ 9,545,818	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,518,282	\$ (988,880)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,836,043	\$ 8,556,938	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 802,946	1
2	Restatements (describe):		2
3	Additional income from 2011 rate change	237,103	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,040,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	849,233	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	(371,000)	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)	\$ 478,233	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)	\$ 1,518,282	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128Report Period Beginning: 01/01/12Ending: 12/31/12

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	\$ 4,188,151	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,188,151	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy		6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue			
9 Payments for Education		9	
10 Other Government Grants		10	
11 CNA Training Reimbursements		11	
12 Gift and Coffee Shop		12	
13 Barber and Beauty Care		13	
14 Non-Patient Meals		14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs		17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray		20	
21 Other Medical Services		21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	116	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 116	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,188,267	30	

	1	2	
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	754,551	31	
32 Health Care	1,426,127	32	
33 General Administration	756,398	33	
B. Capital Expense			
34 Ownership	256,598	34	
C. Ancillary Expense			
35 Special Cost Centers		35	
36 Provider Participation Fee	145,360	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,339,034	40	
41 Income before Income Taxes (line 30 minus line 40)**	849,233	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 849,233	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 2,787,544	44	
45 Private Pay - Net Inpatient Revenue	101,520	45	
46 Medicare - Net Inpatient Revenue	1,299,087	46	
47 Other-(specify)		47	
48 Other-(specify)		48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,188,151	49	

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? no,cash basis 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	1,784	1,992	\$ 74,435	\$ 37.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,852	9,318	273,117	29.31	3
4	Licensed Practical Nurses	11,365	12,408	341,589	27.53	4
5	CNAs & Orderlies			470,863		5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	395	551	7,289	13.23	9
10	Activity Assistants	3,589	3,685	31,008	8.41	10
11	Social Service Workers	1,956	2,088	41,760	20.00	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,104	37,878	18.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,389	10,064	100,767	10.01	15
16	Dishwashers					16
17	Maintenance Workers	2,901	3,052	44,921	14.72	17
18	Housekeepers	12,586	13,671	162,099	11.86	18
19	Laundry					19
20	Administrator	2,024	2,206	94,235	42.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,789	6,025	59,866	9.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	62,582	67,164	\$ 1,739,827 *	\$ 25.90	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	96	\$ 4,525	1-3	35
36	Medical Director	586	41,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	275	18,000	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	30	1,239	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	987	\$ 64,764		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.

STATE OF ILLINOIS

0046128

Report Period Beginning:

01/01/12

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Ending: 12/31/12

Facility Name & ID Number

Elmwood Terrace Healthcare Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine Wood	Administrator		\$ 94,235
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,235

B. Administrative - Other

Description	Amount
Management fee- David Abell	\$ 21,000
Management Fee- Jospeh Brandman	21,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 42,000

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	\$ 10,950
Richard Peelo	Accounting	6,200
Frost Ruttenberg	Public Aid Consulting	5,697
Mcvey & Parsky	Legal	9,176
Stephen Sher	Legal Adj Out	2,045
Meyer Magence	Legal	2,207
Much Shelist	Legal	170
National Datacare	Trust Fees	1,250
Much Shelist	Legal adj- Out	15,027
Personnel Planners	UC Tax Consultant	905
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)	\$ 53,627	

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 64,358
Unemployment Compensation Insurance	76,058
FICA Taxes	133,097
Employee Health Insurance	32,205
Employee Meals	3,000
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 308,718

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	\$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 30	300
Advertising	5,516
Chicago Sun Times	1,742
Less: Public Relations Expense	()
Non-allowable advertising	(5,516)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,032

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Coms Interactive	21,577
Embrace	1,133
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 22,710

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. _____ (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____ (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____ (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>6,500</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____ (9) Are you presently operating under a sublease agreement? YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> 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. \$ <u>145,360</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>No</u> 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. \$ <u>3,000</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____ (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____ c. What percent of all travel expense relates to transportation of nurses and patients? <u>0</u> d. Have vehicle usage logs been maintained? <u>No</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>No</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>No</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>0</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? <u>Yes</u> (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? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.
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