		FOR BHF USE			

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0046128

Facility Name: Elmwood Terrace Healthcare Center

Address: 1017 West Galena (Number) Aurora (City) 60506 (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		PROPRIETARY		GOVERNMENTAL
[ ]	Charitable Corp.	[X]		[ ]	
[ ]	Trust	[ ]	Individual	[ ]	State
		[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	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 01/01/10 to 12/31/10 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 # 847-933-1283

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: 01/01/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	68	24,820	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	68	TOTALS	68	24,820	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,708	130	3,627	5,465	8
9	SNF/PED					9
10	ICF	15,300	1,170		16,470	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,008	1,300	3,627	21,935	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.38%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 02/18/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 68 and days of care provided 3,627

Medicare Intermediary Riverbend

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number: Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,863	7,387	4,775	133,025		133,025		133,025			1
2	Food Purchase		135,587		135,587	(3,000)	132,587		132,587			2
3	Housekeeping	139,214	32,017	14,410	185,641		185,641		185,641			3
4	Laundry		8,416		8,416		8,416		8,416			4
5	Heat and Other Utilities			87,163	87,163		87,163		87,163			5
6	Maintenance	47,809		41,448	89,257		89,257		89,257			6
7	Other (specify):*											7
8	**TOTAL General Services**	307,886	183,407	147,796	639,089	(3,000)	636,089		636,089			8
	B. Health Care and Programs											
9	Medical Director			36,875	36,875		36,875		36,875			9
10	Nursing and Medical Records	1,045,830	106,027	19,900	1,171,757		1,171,757		1,171,757			10
10a	Therapy			14,707	14,707		14,707		14,707			10a
11	Activities	34,250	4,928		39,178		39,178		39,178			11
12	Social Services	33,530		4,399	37,929		37,929		37,929			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,113,610	110,955	75,881	1,300,446		1,300,446		1,300,446			16
	C. General Administration											
17	Administrative	75,015		58,844	133,859		133,859		133,859			17
18	Directors Fees											18
19	Professional Services			48,677	48,677		48,677		48,677			19
20	Dues, Fees, Subscriptions & Promotions			7,320	7,320		7,320	(3,062)	4,258			20
21	Clerical & General Office Expenses	64,110	49,752	47,963	161,825		161,825	(2,036)	159,789			21
22	Employee Benefits & Payroll Taxes			238,954	238,954	3,000	241,954		241,954			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,067	2,067		2,067		2,067			24
25	Other Admin. Staff Transportation			3,514	3,514		3,514		3,514			25
26	Insurance-Prop.Liab.Malpractice			68,033	68,033		68,033		68,033			26
27	Other (specify):*											27
28	**TOTAL General Administration**	139,125	49,752	475,372	664,249	3,000	667,249	(5,098)	662,151			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,560,621	344,114	699,049	2,603,784		2,603,784	(5,098)	2,598,686			29

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center #0046128 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			533,510	533,510		533,510	(482,650)	50,860			30
31	Amortization of Pre-Op. & Org.							1,771	1,771			31
32	Interest			30,863	30,863		30,863	65,415	96,278			32
33	Real Estate Taxes							37,928	37,928			33
34	Rent-Facility & Grounds			140,000	140,000		140,000	(140,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			704,373	704,373		704,373	(517,536)	186,837			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			37,230	37,230		37,230		37,230			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			37,230	37,230		37,230		37,230			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,560,621	344,114	1,440,652	3,345,387		3,345,387	(522,634)	2,822,753			45

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(498,083)	30		9
10	Interest and Other Investment Income	(96)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,562)	21		11
12	Non-Working Officer's or Owner's Salary	(186)	21		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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,062)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (503,989)		$	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)	(18,645)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (18,645)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (522,634)		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

STATE OF ILLINOIS

Elmwood Terrace Healthcare Center

ID# 0046128

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,062)	0	0	0	0	0	0	0	0	0	0	(3,062)	20
21	Clerical & General Office Expenses	(2,748)	712	0	0	0	0	0	0	0	0	0	(2,036)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,810)	712	0	0	0	0	0	0	0	0	0	(5,098)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,810)	712	0	0	0	0	0	0	0	0	0	(5,098)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(498,083)	15,433	0	0	0	0	0	0	0	0	0	(482,650)	30
31	Amortization of Pre-Op. & Org.	0	1,771	0	0	0	0	0	0	0	0	0	1,771	31
32	Interest	(96)	65,511	0	0	0	0	0	0	0	0	0	65,415	32
33	Real Estate Taxes	0	37,928	0	0	0	0	0	0	0	0	0	37,928	33
34	Rent-Facility & Grounds	0	(140,000)	0	0	0	0	0	0	0	0	0	(140,000)	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**	(498,179)	(19,357)	0	0	0	0	0	0	0	0	0	(517,536)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(503,989)	(18,645)	0	0	0	0	0	0	0	0	0	(522,634)	45

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule				Elmwood LLC	Aurora	Bldg Rental

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. [X] 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	$ 140,000	Elmwood Terrace, LLC	100.00%	$	$ (140,000)	1
2	V	32	Interest		Elmwood Terrace, LLC		65,511	65,511	2
3	V	33	Real Estate Tax		Elmwood Terrace, LLC		37,928	37,928	3
4	V	30	Depreciation		Elmwood Terrace, LLC		15,433	15,433	4
5	V	31	Amortization		Elmwood Terrace, LLC		1,771	1,771	5
6	V	21	Office		Elmwood Terrace, LLC		712	712	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 140,000			$ 121,355	$ * (18,645)	14

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

Facility Name & ID Number: Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	David Abell		Management	4.99		20	50.00	Management	$ 29,422	17-3	1
2	Joseph Brandman		Management	7.80		20	50.00	Management	29,422	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	$ 58,844		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: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number ( )

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 [X]

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	03/15/04	$ 1,200,000	$ 1,018,419	03/15/15	8.2500	$ 65,511	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Working Capital		03/06/03	450,000	444,000		8.7500	30,863	6
7												7
8												8
9	TOTAL Facility Related				$7,968.51		$ 1,650,000	$ 1,462,419			$ 96,374	9
	B. Non-Facility Related*											
10	Interest Income										(96)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (96)	14
15	TOTALS (line 9+line14)						$ 1,650,000	$ 1,462,419			$ 96,278	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.)

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2009 report.	$	32,067	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.)	$	34,651	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,584	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	35,344	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.	$	37,928	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2005	32,344	8
2006	27,005	9
2007	31,177	10
2008	31,438	11
2009	34,900	12

34651 x 1.02

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.**

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-20-276-013		$ 4,131.00	$ 4,131.00
2.	15-20-276-014		$ 30,520.00	$ 30,520.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,651.00	$ 34,651.00

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: ________ B. General Construction Type: Exterior ________ Frame ________ Number of Stories ________

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 26,572
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 1,771
4. Dates Incurred: 03/04

Nature of Costs: Closing 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			2003	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		2003		$ 300,000	$ 15,433	27.5	$ 10,909	$ (4,524)	$ 85,908	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Paving			2005	11,969	435	27.5	435		2,338	9
10	Tiling			2005	3,895	142	27.5	142		799	10
11	Alarms			2005	9,818	357	27.5	357		2,068	11
12	Corridor Renovation			2010							12
13	New Floor				37,224	37,224	27.5	1,354	(35,870)	1,354	13
14	Wallcovering				8,400	8,400	27.5	305	(8,095)	305	14
15	Hand Rails,Bumper Guards, And Corner Guards				21,479	21,479	27.5	781	(20,698)	781	15
16	Installation of Door Casings				10,125	10,125	27.5	368	(9,757)	368	16
17	Light Fixtures				9,880	9,880	27.5	359	(9,521)	359	17
18	Custom Signage				3,661	3,661	27.5	133	(3,528)	133	18
19	Resident Rooms Renovation			2010							19
20	Remove Existing Cove Base and Install new cove Base				38,334	38,334	27.5	1,394	(36,940)	1,394	20
21	Room Renovation				32,671	32,671	27.5	1,188	(31,483)	1,188	21
22	Bumper guards				6,984	6,984	27.5	254	(6,730)	254	22
23	Cubicle Curtains				14,852	14,852	27.5	540	(14,312)	540	23
24	Head and Foot Boards				7,300	7,300	27.5	265	(7,035)	265	24
25	Window Treatments				10,531	10,531	27.5	383	(10,148)	383	25
26	Wall Sconces				5,321	5,321	27.5	193	(5,128)	193	26
27	Ligth Fixtures				17,953	17,953	27.5	653	(17,300)	653	27
28	Bathroom Renovation			2010							28
29	New Floor				10,185	10,185	27.5	370	(9,815)	370	29
30	Mirrors				2,657	2,657	27.5	97	(2,560)	97	30
31	Lighting				3,408	3,408	27.5	124	(3,284)	124	31
32	Nurses Station Renovation				10,348	10,348	27.5	376	(9,972)	376	32
33	Dining Room Renovation			2010							33
34	New Floor				8,103	8,103	27.5	295	(7,808)	295	34
35	Wallcovering				2,053	2,053	27.5	75	(1,978)	75	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	1,859	27.5	68	(1,791)	68	38
39	Wallcovering		1,524	1,524	27.5	55	(1,469)	55	39
40	Window Treatments		699	699	27.5	25	(674)	25	40
41	Renovating Beauty Salon	2010							41
42	New Floor		1,812	1,812	27.5	66	(1,746)	66	42
43	Wallcovering		1,415	1,415	27.5	51	(1,364)	51	43
44	Custom Cabinets		8,125	8,125	27.5	295	(7,830)	295	44
45	Lighting		1,354	1,354	27.5	49	(1,305)	49	45
46	Shampoo Station		1,950	1,950	27.5	71	(1,879)	71	46
47	Corridors, Business Office, Small Dining Room,	2010							47
48	Main Dining Room, DON Office, Lounge								48
49	Painting and Wallcoverings		69,500	69,500	27.5	2,527	(66,973)	2,527	49
50	Install New Windows	2010	32,000	32,000	27.5	1,164	(30,836)	1,164	50
51	Install Dining Room Window Treatments	2010	743	743	27.5	27	(716)	27	51
52	Repaving Parking Lot	2010	39,550	39,550	27.5	1,438	(38,112)	1,438	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									69
70	TOTAL (lines 4 thru 69)		$ 747,682	$ 438,367		$ 27,188	$ (411,179)	$ 106,458	70

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 128,015	$ 1,866	$ 12,801	$ 10,935	10	$ 98,151	71
72	Current Year Purchases	108,710	108,710	10,871	(97,839)	10	10,871	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 236,725	$ 110,576	$ 23,672	$ (86,904)		$ 109,022	75

D. Vehicle Depreciation (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)	$ 1,034,407	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 548,943	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 50,860	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (498,083)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 215,480	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								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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

2. CLASSROOM PORTION:
   IN-HOUSE PROGRAM [ ]
   IN OTHER FACILITY [ ]
   COMMUNITY COLLEGE [ ]
   HOURS PER CNA ____

3. CLINICAL PORTION:
   IN-HOUSE PROGRAM [ ]
   IN OTHER FACILITY [ ]
   HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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.

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (106,787)	$ (106,465)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	638,589	638,589	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,355	28,355	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Others	116,843	115,925	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 677,000	$ 676,404	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	408,132	408,132	15
16	Equipment, at Historical Cost	136,725	236,725	16
17	Accumulated Depreciation (book methods)	(562,084)	(747,992)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	117,399	143,971	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(117,399)	(129,433)	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)**	$ 219,473	$ 498,103	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 896,473	$ 1,174,507	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 86,832	$ 86,832	26
27	Officer's Accounts Payable	162,500	162,500	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	444,000	444,000	29
30	Accrued Salaries Payable	13,712	13,712	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,521		31
32	Accrued Real Estate Taxes(Sch.IX-B)		35,344	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Others	123,580	123,580	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 836,145	$ 865,968	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,018,419	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,018,419	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 836,145	$ 1,884,387	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 60,328	$ (709,880)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 896,473	$ 1,174,507	48

*(See instructions.)

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 142,708	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 142,708	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	293,620	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	(376,000)	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)**	$ (82,380)	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)**	$ 60,328	24 *

*** This must agree with page 17, line 47.**

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,638,911	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,638,911	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***	96	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 96	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)**	$ 3,639,007	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	639,089	31
32	Health Care	1,300,446	32
33	General Administration	664,249	33
	B. Capital Expense		
34	Ownership	704,373	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,230	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,345,387	40
41	**Income before Income Taxes (line 30 minus line 40)****	293,620	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 293,620	43

* 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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,200	$ 71,783	$ 32.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,773	6,598	182,439	27.65	3
4	Licensed Practical Nurses	12,595	13,465	336,232	24.97	4
5	CNAs & Orderlies	37,351	40,355	455,376	11.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,145	1,257	15,590	12.40	9
10	Activity Assistants	2,017	2,297	18,660	8.12	10
11	Social Service Workers	1,984	2,152	33,530	15.58	11
12	Dietician					12
13	Food Service Supervisor	2,120	2,176	36,692	16.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,102	9,622	84,171	8.75	15
16	Dishwashers					16
17	Maintenance Workers	3,135	3,241	47,809	14.75	17
18	Housekeepers	1,215	13,088	139,214	10.64	18
19	Laundry					19
20	Administrator	2,048	2,232	75,015	33.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,015	4,317	64,110	14.85	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)	84,508	103,000	$ 1,560,621 *	$ 15.15	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	80	$ 4,775	1-3	35
36	Medical Director	530	36,875	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	300	19,500	10-3	38
39	Pharmacist Consultant	10	400	10-3	39
40	Physical Therapy Consultant	226	14,707	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	105	4,399	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,251	$ 80,656		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine Wood	Administrator		$ 75,015
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,015

B. Administrative - Other

Description	Amount
Management Fee - David Abell	$ 29,422
Management Fee - Joseph Brandman	29,422
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 58,844

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	$ 10,950
Richard Peelo	Accounting	6,200
Personnel Planners	UC Tax Consultant	2,774
Frost Ruttenberg	Public Aid Consultant	850
National Datacare	Trust Fees	1,333
Neal Gerber & Eisenberg	Legal	20,257
Meyer Magence	Legal	6,313
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 48,677

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,013
Unemployment Compensation Insurance	28,450
FICA Taxes	119,387
Employee Health Insurance	24,104
Employee Meals	3,000
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 241,954

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	568
Health Care Worker Background Check	1,700
(Indicate # of checks performed 170)	
Patient Background Checks	
Advertising	3,062
Less: Public Relations Expense	( )
Non-allowable advertising	(3,062)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,258

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
ICLTC	2,067
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,067

**See instructions.

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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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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? **No**
If YES, give association name and amount. ______

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? ______

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? ______

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **27.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,500** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. ______

(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. $ **37,230**
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. $ **3,000** Has any meal income been offset against related costs? **No** Indicate the amount. $ ______

(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. $ ______
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
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. $ **0**

(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.