

Facility Name & ID Number Elmwood Terrace Healthcare Center

0046128 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	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				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	1,755	75	4,084	5,914	8
9	SNF/PED					9
10	ICF	15,794	677		16,471	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,549	752	4,084	22,385	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.19%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/18/03

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/18/03 NO

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 4,084

Medicare Intermediary Riverbend

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	132,145	8,000	4,500	144,645		144,645		144,645		1
2	Food Purchase		180,204		180,204	(3,000)	177,204		177,204		2
3	Housekeeping	158,999	26,651	24,906	210,556		210,556		210,556		3
4	Laundry		12,704		12,704		12,704		12,704		4
5	Heat and Other Utilities			85,609	85,609		85,609		85,609		5
6	Maintenance	48,696		86,945	135,641		135,641		135,641		6
7	Other (specify):*										7
8	TOTAL General Services	339,840	227,559	201,960	769,359	(3,000)	766,359		766,359		8
	B. Health Care and Programs										
9	Medical Director			39,000	39,000		39,000		39,000		9
10	Nursing and Medical Records	1,121,573	157,000	18,000	1,296,573		1,296,573		1,296,573		10
10a	Therapy										10a
11	Activities	50,124	4,224		54,348		54,348		54,348		11
12	Social Services	35,151		870	36,021		36,021		36,021		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,206,848	161,224	57,870	1,425,942		1,425,942		1,425,942		16
	C. General Administration										
17	Administrative	96,255		42,000	138,255		138,255		138,255		17
18	Directors Fees										18
19	Professional Services			26,701	26,701		26,701	(1,375)	25,326		19
20	Dues, Fees, Subscriptions & Promotions			17,498	17,498		17,498	(6,424)	11,074		20
21	Clerical & General Office Expenses	47,134	59,270	44,452	150,856		150,856	(3,152)	147,704		21
22	Employee Benefits & Payroll Taxes			252,977	252,977	3,000	255,977		255,977		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,885	7,885		7,885		7,885		24
25	Other Admin. Staff Transportation			32	32		32		32		25
26	Insurance-Prop.Liab.Malpractice			66,110	66,110		66,110		66,110		26
27	Other (specify):*										27
28	TOTAL General Administration	143,389	59,270	457,655	660,314	3,000	663,314	(10,951)	652,363		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,690,077	448,053	717,485	2,855,615		2,855,615	(10,951)	2,844,664		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: 01/01/11 Ending: 12/31/11

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			2,164	2,164		2,164	48,694	50,858			30
31	Amortization of Pre-Op. & Org.							1,771	1,771			31
32	Interest			28,589	28,589		28,589	56,225	84,814			32
33	Real Estate Taxes							40,572	40,572			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			210,753	210,753		210,753	(32,738)	178,015			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)	1,690,077	448,053	965,468	3,103,598		3,103,598	(43,689)	3,059,909			45

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

VI. ADJUSTMENT DETAIL

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

		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	37,785	30		9
10	Interest and Other Investment Income	(102)	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	(57)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,375)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,424)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,145)	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)	\$ 21,682		\$	30

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)	(65,371)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (65,371)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (43,689)		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

BHF USE ONLY							
48		49		50		51	52

Elmwood Terrace Healthcare Center

ID# 0046128

Report Period Beginning: 01/01/11

Ending: 12/31/11

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:

01/01/11

Ending:

12/31/11

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	(6,375)	5,000	0	0	0	0	0	0	0	0	0	(1,375)	19
20	Fees, Subscriptions & Promotions	(6,424)	0	0	0	0	0	0	0	0	0	0	(6,424)	20
21	Clerical & General Office Expenses	(3,202)	50	0	0	0	0	0	0	0	0	0	(3,152)	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	(16,001)	5,050	0	0	0	0	0	0	0	0	0	(10,951)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,001)	5,050	0	0	0	0	0	0	0	0	0	(10,951)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	37,785	10,909	0	0	0	0	0	0	0	0	0	48,694	30
31	Amortization of Pre-Op. & Org.	0	1,771	0	0	0	0	0	0	0	0	0	1,771	31
32	Interest	(102)	56,327	0	0	0	0	0	0	0	0	0	56,225	32
33	Real Estate Taxes	0	40,572	0	0	0	0	0	0	0	0	0	40,572	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	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	37,683	(70,421)	0	0	0	0	0	0	0	0	0	(32,738)	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)	21,682	(65,371)	0	0	0	0	0	0	0	0	0	(43,689)	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
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. 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 180,000	Elmwood Terrace, LLC	100.00%	\$	(180,000)	1
2	V	32 Interest		Elmwood Terrace, LLC		56,327	56,327	2
3	V	33 Real Estate Tax		Elmwood Terrace, LLC		40,572	40,572	3
4	V	30 Depreciation		Elmwood Terrace, LLC		10,909	10,909	4
5	V	31 Amortization		Elmwood Terrace, LLC		1,771	1,771	5
6	V	21 Office		Elmwood Terrace, LLC		50	50	6
7	V	19 Professional Fess		Elmwood Terrace, LLC		5,000	5,000	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 180,000			\$ 114,629	\$ * (65,371)	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: 01/01/11 Ending: 12/31/11

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	4.99		20	50.00	Management	\$ 21,000	17-3	1
2	Joseph Brandman		Management	13.80		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:

01/01/11

Ending: 12/31/11

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

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/11 Ending: 12/31/11

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										
										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	\$ 941,033	031515	8.2500	\$ 56,327	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	MB Financial		X	Working Capital		03/06/03	450,000	1,200,000		8.7500	28,589	6							
7												7							
8												8							
9	TOTAL Facility Related				\$7,968.51		\$ 1,650,000	\$ 2,141,033			\$ 84,916	9							
B. Non-Facility Related*																			
10	Interest Income										(102)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (102)	14							
15	TOTALS (line 9+line14)						\$ 1,650,000	\$ 2,141,033			\$ 84,814	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.)

2010 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>15-20-276-013</u>	<u></u>	\$ <u>3,938.00</u>	\$ <u></u>
2.	<u>15-20-276-014</u>	<u></u>	\$ <u>33,658.00</u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>37,596.00</u></u>	\$ <u><u></u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Elmwood Terrace Healthcare Center

0046128

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>14,166</u>	<u>2003</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	14,166		\$ 50,000	3

Facility Name & ID Number Elmwood Terrace Healthcare Center

0046128

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	\$	\$ 96,817	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Paving		2005	11,969	435	27.5	435		2,773	9
10	Tiling		2005	3,895	142	27.5	142		941	10
11	Alarms		2005	9,818	357	27.5	357		2,425	11
12	Corridor Renovation		2010							12
13	New Floor			37,224		27.5	1,354	1,354	2,708	13
14	Wallcovering			8,400		27.5	305	305	610	14
15	Hand Rails, Bumper Guards, and Corner Guards			21,479		27.5	781	781	1,562	15
16	Installation of Door Casings			10,125		27.5	368	368	736	16
17	Light Fixtures			9,880		27.5	359	359	718	17
18	Custom Signage			3,661		27.5	133	133	266	18
19	Resident Rooms Renovation		2010							19
20	Remove Existing Cove Base and Install New Cove Base			38,334		27.5	1,394	1,394	2,788	20
21	Room Renovation			32,671		27.5	1,188	1,188	2,376	21
22	Bumper Guards			6,984		27.5	254	254	508	22
23	Cubicle Curtains			14,852		27.5	540	540	1,080	23
24	Head and Foot Boards			7,300		27.5	265	265	530	24
25	Window Treatments			10,531		27.5	383	383	766	25
26	Wall Scones			5,321		27.5	193	193	386	26
27	Light Fixtures			17,953		27.5	653	653	1,306	27
28	Bathroom Renovation		2010							28
29	New Floor			10,185		27.5	370	370	740	29
30	Mirrors			2,657		27.5	97	97	194	30
31	Lighting			3,408		27.5	124	124	248	31
32	Nurses Station Renovation			10,348		27.5	376	376	752	32
33	Dining Room Renovation		2010							33
34	New Floor			8,103		27.5	295	295	590	34
35	Wallcovering			2,053		27.5	75	75	150	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:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2010	\$	\$		\$	\$	\$	37
38		1,859		27.5	68	68	136	38
39		1,524		27.5	55	55	110	39
40		699		27.5	25	25	50	40
41	2010							41
42		1,812		27.5	66	66	132	42
43		1,415		27.5	51	51	102	43
44		8,125		27.5	295	295	590	44
45		1,354		27.5	49	49	98	45
46		1,950		27.5	71	71	142	46
47	2010							47
48								48
49		69,500		27.5	2,527	2,527	5,054	49
50	2010	32,000		27.5	1,164	1,164	2,328	50
51	2010	743		27.5	27	27	54	51
52	2010	39,550		27.5	1,438	1,438	2,876	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		\$ 747,682	\$ 11,843		\$ 27,186	\$ 15,343	\$ 133,642	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:

01/01/11

Ending:

12/31/11

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	\$ 1,230	\$ 23,672	\$ 22,442	10	\$ 132,696	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 236,725	\$ 1,230	\$ 23,672	\$ 22,442		\$ 132,696	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)	\$ 1,034,407	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,073	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,858	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 37,785	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 266,338	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	Vacant House	\$ 236,700	\$	\$ 8,607	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 236,700	\$	\$ 8,607	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? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								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.	<u>/2012</u>	\$ _____
13.	<u>/2013</u>	\$ _____
14.	<u>/2014</u>	\$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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 prescripts							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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/11**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (104,579)	\$ (104,579)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,932,243	1,932,243	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,419	73,419	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Others	209,443	209,443	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,110,526	\$ 2,110,526	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	516,841	516,841	15
16	Equipment, at Historical Cost	136,725	236,725	16
17	Accumulated Depreciation (book methods)	(672,957)	(869,774)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	117,399	143,971	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(117,399)	(131,204)	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)	\$ 217,309	\$ 483,259	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,327,835	\$ 2,593,785	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 186,297	\$ 186,297	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,200,000	1,200,000	29
30	Accrued Salaries Payable	5,417	5,417	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,861	7,861	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,320	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	16,042	16,042	35
Other Current Liabilities(specify):				
36	Due to Others	109,272	109,272	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,524,889	\$ 1,563,209	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		941,033	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)	\$	\$ 941,033	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,524,889	\$ 2,504,242	46
47	TOTAL EQUITY(page 18, line 24)	\$ 802,946	\$ 89,543	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,327,835	\$ 2,593,785	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 60,328	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 60,328	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,072,618	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	(330,000)	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)	\$ 742,618	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)	\$ 802,946	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128Report Period Beginning: 01/01/11Ending: 12/31/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,176,114	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,176,114	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***	102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 102	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)	\$ 4,176,216	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	769,359	31
32	Health Care	1,425,942	32
33	General Administration	660,314	33
B. Capital Expense			
34	Ownership	210,753	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)*	\$ 3,103,598	40
41	Income before Income Taxes (line 30 minus line 40)**	1,072,618	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,072,618	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? O,CASH BAS 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.

Facility Name & ID Number **Elmwood Terrace Healthcare Center**

0046128

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	1,920	2,080	\$ 78,954	\$ 37.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,107	9,682	264,011	27.27	3
4	Licensed Practical Nurses	11,029	12,045	314,645	26.12	4
5	CNAs & Orderlies	37,950	40,734	463,963	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,010	2,097	27,574	13.15	9
10	Activity Assistants	2,856	2,943	22,550	7.66	10
11	Social Service Workers	1,952	2,082	35,151	16.88	11
12	Dietician					12
13	Food Service Supervisor	1,934	2,119	36,657	17.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,216	9,774	95,488	9.77	15
16	Dishwashers					16
17	Maintenance Workers	3,095	3,306	48,696	14.73	17
18	Housekeepers	15,109	16,134	158,999	9.85	18
19	Laundry					19
20	Administrator	2,008	2,168	96,255	44.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,337	4,512	47,134	10.45	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)	102,523	109,676	\$ 1,690,077 *	\$ 15.41	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	557	39,000	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	21	870	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	853	\$ 57,870		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Catherine Wood	Administrator		\$ 96,255	Workers' Compensation Insurance	\$ 70,225	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	35,881	Advertising: Employee Recruitment		
				FICA Taxes	129,291	Health Care Worker Background Check	1,000	
				Employee Health Insurance	17,580	(Indicate # of checks performed <u>100</u>)		
				Employee Meals	3,000	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		CHICAGO SUN TIMES	1,931	
						AURORA REGIONAL CHAMBER	275	
						Advertising	6,424	
						Misc Permits	3,335	
						Misc licenses	553	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(6,424)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,255					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 255,977	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,074	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee- David Abell			\$ 21,000				Out-of-State Travel	\$
Management Fee- Joseph Brandman			21,000					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 42,000				Seminar Expense	
							ICLTC	3,185
							COMS INTERACTIVE	4,200
							EMBRACE MEDICAL TRAINING	500
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 26,701	TOTAL		\$	TOTAL	\$ 7,885

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? 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? N/A
- (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 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.