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.

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

I. IDPH License ID Number: 0008300

Facility Name: Elizabeth Nursing Home

Address: 540 Pleasant Street (Number) Elizabeth (City) 61028 (Zip Code)

County: JoDaviess

Telephone Number: (815) 858-2275 **Fax #** (815) 858-2596

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1968

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Karen Wilson **Telephone Number:** (815) 858-2275
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Karen Wilson
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Joseph D. Splinter, CPA, Senior Manager
(Firm Name & Address) Eide Bailly, LLP, 3999 Pennsylvania Ave., Suite 100 Dubuque, IA 52002
(Telephone) (563) 556-1790 Fax # (563) 557-7842

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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1 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		Skilled (SNF)			1
2	49	Skilled Pediatric (SNF/PED)	49	17,934	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	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					8
9	SNF/PED					9
10	ICF	4,518	7,658		12,176	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,518	7,658		12,176	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.89%

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)
Assisted Living Facility, Rental of Clinic Space

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 07/08/1968

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	156,284	6,984	5,130	168,398		168,398		168,398			1
2	Food Purchase		95,354		95,354		95,354	(1,997)	93,357			2
3	Housekeeping	40,771	12,402		53,173		53,173		53,173			3
4	Laundry	33,370	6,676		40,046		40,046		40,046			4
5	Heat and Other Utilities											5
6	Maintenance	57,392	18,123	62,850	138,365		138,365		138,365			6
7	Other (specify):*											7
8	**TOTAL General Services**	287,817	139,539	67,980	495,336		495,336	(1,997)	493,339			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	698,521	46,753	18,052	763,326		763,326		763,326			10
10a	Therapy											10a
11	Activities	44,365	2,361	360	47,086		47,086		47,086			11
12	Social Services	29,467		1,620	31,087		31,087		31,087			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	772,353	49,114	20,032	841,499		841,499		841,499			16
	C. General Administration											
17	Administrative	72,761	11,292	20,602	104,655	(2,262)	102,393	(18,641)	83,752			17
18	Directors Fees			3,800	3,800		3,800		3,800			18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses											21
22	Employee Benefits & Payroll Taxes			263,892	263,892	(39,585)	224,307		224,307			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,646	81,646	(29,193)	52,453		52,453			26
27	Other (specify):*											27
28	**TOTAL General Administration**	72,761	11,292	369,940	453,993	(71,040)	382,953	(18,641)	364,312			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,132,931	199,945	457,952	1,790,828	(71,040)	1,719,788	(20,638)	1,699,150			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 Elizabeth Nursing Home #0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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			118,205	118,205	(75,315)	42,890	(3,969)	38,921			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,590	3,590		3,590	(3,411)	179			32
33	Real Estate Taxes			58,230	58,230	(36,232)	21,998	(3,425)	18,573			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			180,025	180,025	(111,547)	68,478	(10,805)	57,673			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			140,950	140,950		140,950		140,950			42
43	Other (specify):* **Assisted Living**	201,647	85,779	81,723	369,149	182,587	551,736		551,736			43
44	**TOTAL Special Cost Centers**	201,647	85,779	222,673	510,099	182,587	692,686		692,686			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,334,578	285,724	860,650	2,480,952		2,480,952	(31,443)	2,449,509			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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	(1,997)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(17,539)	17		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,411)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,425)	33		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				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	(5,071)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,443)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (31,443)		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

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending machine revenue/activity	$ (1,102)	17	1
2	Clinic building depreciation	(3,611)	30	2
3	ALU land improvements depreciation	(358)	30	3
4	Miscellaneous	0	17	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**	(5,071)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elizabeth Nursing Home # 0008300 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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

	Operating Expenses	PAGES 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	(1,997)	0	0	0	0	0	0	0	0	0	0	(1,997)	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**	(1,997)	0	0	0	0	0	0	0	0	0	0	(1,997)	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	(18,641)	0	0	0	0	0	0	0	0	0	0	(18,641)	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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**	(18,641)	0	0	0	0	0	0	0	0	0	0	(18,641)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,638)	0	0	0	0	0	0	0	0	0	0	(20,638)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elizabeth Nursing Home # 0008300 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(3,969)	0	0	0	0	0	0	0	0	0	0	(3,969)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,411)	0	0	0	0	0	0	0	0	0	0	(3,411)	32
33	Real Estate Taxes	(3,425)	0	0	0	0	0	0	0	0	0	0	(3,425)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,805)	0	0	0	0	0	0	0	0	0	0	(10,805)	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)**	(31,443)	0	0	0	0	0	0	0	0	0	0	(31,443)	45

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
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19								19
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21								21
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Darlene Read	Shareholder	Board Member	0.06		1.5	0.04	Director Fees	$ 900		1
2	Penny Heidenreich	Shareholder	Board Member	0.01		1.5	0.04	Director Fees	150		2
3	Nancy Walker	Shareholder	Board Member	0.01		1.5	0.04	Director Fees	775		3
4	Marvin Wurster	Shareholder	Board Member	0.06		1.5	0.04	Director Fees	475		4
5	Ken Haas	Shareholder	Board Member	0.03		1.5	0.04	Director Fees	275		5
6	Ted Krohmer	Shareholder	Board Member	0.02		1.5	0.04	Director Fees	300		6
7	Wayne Trost	Shareholder	Board Member	0.02		1.5	0.04	Director Fees	300		7
8	Carol Rayhorn	Shareholder	Board Member	0.04		1.5	0.04	Director Fees	300		8
9	Donald Brudi	Shareholder	Board Member	0.01		1.5	0.04	Director Fees	275		9
10	Clark Gerleman	Shareholder	Board Member	0.01		1.5	0.04	Director Fees	50		10
11	Karen Wilson	Administrator	Administrator	0.00		40	100.00	Compensation	47,481		11
12											12
13								TOTAL	$ 51,281		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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

	1 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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Shareholder Loans	X		Assisted Living Facility	Various	Various	1,438,979	1,438,979	2/1/32	5.5000	81,723	10
11	Elizabeth State Bank		X	Clinic Building	$1,050.90	10/15/06	140,000	92,969	7/17/16	1.25/5.28	3,411	11
12	Shareholder Loans	X		Operations	Various	Various	80,000	80,000	02/01/2032	4.7500	179	12
13												13
14	TOTAL Non-Facility Related				$1,050.90		$ 1,658,979	$ 1,611,948			$ 85,313	14
15	TOTALS (line 9+line14)						$ 1,658,979	$ 1,611,948			$ 85,313	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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 52,000	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.)		$ 54,230	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,230	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,000	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.		$ 58,230	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	48,990	8
	2008	50,231	9
	2009	49,739	10
	2010	52,031	11
	2011	54,031	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elizabeth Nursing Home COUNTY JoDaviess

FACILITY IDPH LICENSE NUMBER 0008300

CONTACT PERSON REGARDING THIS REPORT Karen Wilson

TELEPHONE (815) 858-2275 FAX #: (815) 858-2596

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-002-348-06	S25 T27 R2E PT NE NE	$ 58,230.00	$ 15,157.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,230.00	$ 15,157.00

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? X YES _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,294 B. General Construction Type: Exterior Masonry/Siding Frame Masonry/Wood Number of Stories 1

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).

Rented Clinic Area (attached to the Nursing Home complex) - 1,400 sq ft
Assisted Living Facility (attached to the Nursing Home complex) - 22,648 sq ft

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1967	$ 5,275	1
2					2
3	TOTALS			$ 5,275	3

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 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	49		1985	1985	$ 151,186	$	19	$	$	$ 151,186	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Retiling Floor			1986	1,063		19			1,063	9
10	Door and Wall Guards			1986	754		19			754	10
11	B-Label Fire Door			1987	481	15	31.5	15		391	11
12	Rooftop Heat/Cool unit			1987	4,992	159	31.5	159		4,004	12
13	Service Entrance Exit Door			1988	810	26	31.5	26		632	13
14	Windows			1988	12,528	398	31.5	398		9,729	14
15	Retiling Floors			1989	977	31	31.5	31		730	15
16	Vinyl Siding			1989	1,056	34	31.5	34		779	16
17	Front Entrance /Exit Door			1989	860	25	31.5	25		628	17
18	Rooftop Heat/Cool unit			1989	5,555	176	31.5	176		4,060	18
19	Reroof East, North & West			1990	49,329	1,566	31.5	1,566		34,583	19
20	Roof (East & West)			1992	8,194	260	31.5	260		5,332	20
21	Remodel Computer Office			1992	5,872	186	31.5	186		3,819	21
22	Center Structure Roof			1996	7,950	204	39	204		3,295	22
23	26 Toilets			1997	8,443		7			8,443	23
24	S/Wing AC & Heater Unit			1997	4,160		7			4,160	24
25	Kitchen Remodel			1997	22,802	577	39.5	577		8,948	25
26	Exterior Remodel			1997	20,031	507	39.5	507		7,861	26
27	NH Hand Rail			1998	8,483	215	39.5	215		3,114	27
28	Cast Iron Tub			1998	1,482	38	39.5	38		544	28
29	NH Addition			1998	97,742	2,475	39.5	2,475		35,880	29
30	Screen Door System			1999	425	11	39.5	11		145	30
31	140K Heating / Air Conditioning			2000	3,824	98	39	98		1,222	31
32	Energy Efficient Lighting / Outside Lighting			2000	13,621	350	39	350		4,351	32
33	Koehler Utility Sink			2002	667		7			667	33
34	Tile Project - Dining Room			2003	2,113	67	31.5	67		637	34
35	AO Smith Holding Tank			2004	1,324		7			1,324	35
36	Flooring Nurses Station			2004	2,322	74	31.5	74		593	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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ceiling Lights - NH	2004	$ 484	$ 15	31.5	$ 15	$	$ 123	37
38	Suspended Ceiling - Hallway	2004	4,765	151	31.5	151		1,217	38
39	Carpet / Flooring	2005	1,972	63	31.5	63		493	39
40	Sign	2005	551		7			551	40
41	Kitchen Fire Supression System	2005	1,200	38	31.5	38		281	41
42	Telephone Wiring	2005	678	22	31.5	22		159	42
43	Door Security System	2006	11,934	306	39	306		1,976	43
44	Shelves / Cabinets - Activity Room	2006	4,020	164	7	164		4,020	44
45	Garbage Shed	2006	1,437	37	39	37		238	45
46	Fire System	2006	20,553	527	39	527		3,404	46
47	Carbon Monoxide Detecors	2007	570	57	10	57		337	47
48	Boilers	2007	24,648	632	20	632		4,187	48
49	Garbage Disposal	2007	1,001	100	5	100		1,001	49
50	Sewer Line	2007	32,350	1,617	20	1,617		8,492	50
51	Flooring-Halls	2007	793	40	20	40		208	51
52	Dumpster	2007	1,169	117	10	117		594	52
53	Vinyl Flooring & Installation	2007	472	47	10	47		236	53
54	Kitchen Sewer Replacement	2008	6,568	328	20	328		1,615	54
55	Rooftop Airconditioners	2008	11,851	1,185	10	1,185		5,234	55
56	Corridor Door	2008	1,262	126	10	126		547	56
57	Exit Lights	2009	2,834	283	10	283		945	57
58	Roof Repair Gazebo	2011	580	58	10	58		73	58
59	Roof Repair	2012	13,267	995	10	995		995	59
60	Roof	2012	15,540	777	10	777		777	60
61	Spray Fire Protection (exposed steel beams - upstairs)	2012	13,792	690	10	690		690	61
62	Penthouse(Upstairs Remodel)change stair exit (walls, doors, etc.)	2012	23,788	496	20	496		496	62
63	Electrical (part of penthouse (upstairs) remodel	2012	2,199	49	15	49		49	63
64									64
65									65
66	Leasehold Improvements prior to 1981	1981	119,177		10			119,177	66
67	3 Comm Smoke Detectors	1982	603		15			603	67
68	Air Conditioner	1982	931		15			931	68
69	Roof - South Wing	1983	10,500		15			10,500	69
70	TOTAL (lines 4 thru 69)		$ 770,534	$ 16,412		$ 16,412	$	$ 469,023	70

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 770,534	$ 16,412		$ 16,412	$	$ 469,023	1
2	8 - Triple Pane Windows	1984	5,131		18			5,131	2
3	15 Triple Pane Windows	1985	9,124		18			9,124	3
4	Thermiser Vent Control System	1985	2,927		19			2,927	4
5	Office Vision Panels	1985	910		19			910	5
6									6
7	Land Improvements prior to 1981		939		10			939	7
8	Landscaping, tiling, sidewalk	1996	3,143		19			3,143	8
9	Landscaping - shurbs & gravel	1988	850		15			850	9
10	Sidewalks & Landscaping	1990	1,845		15			1,845	10
11	Seal Coat Parking Lot	1990	3,500		15			3,500	11
12	Landscaping	1998	995	58	15	58		995	12
13	Tile Work	1998	1,263	73	15	73		1,263	13
14	Landscaping	1999	1,185	79	15	79		1,125	14
15	Pavement Work	2001	1,840	123	15	123		1,411	15
16	Tree	2001	450	30	15	30		345	16
17	Shrubs and Landscaping Rock	2006	618	41	15	41		268	17
18	Parking Lot	2006	64,828	4,322	15	4,322		28,092	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 870,082	$ 21,138		$ 21,138	$	$ 530,891	34

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 196,090	$ 17,366	$ 17,366	$		$ 135,929	71
72	Current Year Purchases	7,666	417	417			417	72
73	Fully Depreciated Assets	318,270					318,270	73
74								74
75	TOTALS	$ 522,026	$ 17,783	$ 17,783	$		$ 454,616	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)	$ 1,397,383	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,921	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,921	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 985,507	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	Building Imp - Assisted Living	$ 2,742,801	$ 71,645	$ 682,833	86
87	Building - Clinic	140,816	3,611	22,115	87
88	Land Imp - Assisted Living	6,032	358	5,532	88
89	Equipment - Assisted Living	62,555	3,669	49,769	89
90					90
91	TOTALS	$ 2,952,204	$ 79,283	$ 760,249	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.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 33,486	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)	149,131		4
5	Short-Term Investments	6,956		5
6	Prepaid Insurance	11,618		6
7	Other Prepaid Expenses	10,901		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	12,809		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 224,901	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	3,672,244		14
15	Leasehold Improvements, at Historical Cost	87,489		15
16	Equipment, at Historical Cost	584,582		16
17	Accumulated Depreciation (book methods)	(1,745,754)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,603,836	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,828,737	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,167	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	52,877		29
30	Accrued Salaries Payable	129,749		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,452		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,000		32
33	Accrued Interest Payable	14,070		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Provider Assessment Fees	36,639		36
37	Accrued Pension Payable	8,234		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 328,188	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,559,071		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Income Taxes	12,809		43
44	Assisted Living Deposits	18,000		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,589,880	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,918,068	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 910,669	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,828,737	$	48

***(See instructions.)**

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,078,442	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,078,442	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(154,373)	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	(7,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Treasury Stock purchased**	(6,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (167,773)	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)**	$ 910,669	24 *

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,312,177	1
2	Discounts and Allowances for all Levels	(8,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,304,177	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	1,997	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,102	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)**	$ 3,099	23
	D. Non-Operating Revenue		
24	Contributions	1,747	24
25	Interest and Other Investment Income***	17	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,764	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Clinic Rent	17,539	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,539	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,326,579	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	495,336	31
32	Health Care	841,499	32
33	General Administration	453,993	33
	B. Capital Expense		
34	Ownership	180,025	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	140,950	36
	D. Other Expenses (specify):		
37	Assisted Living	369,149	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,480,952	40
41	**Income before Income Taxes (line 30 minus line 40)****	(154,373)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (154,373)	43

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

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2,032	2,032	$ 49,269	$ 24.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,721	7,150	157,520	22.03	3
4	Licensed Practical Nurses	5,333	5,877	107,486	18.29	4
5	CNAs & Orderlies	34,458	36,489	386,867	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,634	3,930	44,365	11.29	10
11	Social Service Workers	1,982	2,150	29,467	13.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,796	14,604	156,284	10.70	15
16	Dishwashers					16
17	Maintenance Workers	3,987	4,323	57,392	13.28	17
18	Housekeepers	3,811	4,122	40,771	9.89	18
19	Laundry	3,236	3,460	33,370	9.64	19
20	Administrator	1,680	1,680	46,634	27.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,329	1,466	23,506	16.03	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Assisted Living	17,191	18,175	201,647	11.09	33
34	TOTAL (lines 1 - 33)	99,190	105,458	$ 1,334,578 *	$ 12.66	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	105	$ 5,130		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	4	313		38
39	Pharmacist Consultant	29	1,215		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	360		44
45	Social Service Consultant	12	360		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	162	$ 7,378		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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1)
(List each licensed administrator separately.) $

B. Administrative - Other

Description	Amount
	$

TOTAL (agree to Schedule V, line 17, col. 3) $
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$

TOTAL (agree to Schedule V, line 19, column 3)
(If total legal fees exceed $5,000, attach copy of invoices.) $

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

**See instructions.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

Facility Name & ID Number Elizabeth Nursing Home **#** 0008300 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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. **IHCA Dues of $3,648**

(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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

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

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

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **140,950**
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? **Yes** 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? **N/A**

(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? **Yes** 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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,997**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eide Bailly, LLP**

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.