



Facility Name & ID Number Elizabeth Nursing Home

# 0008300 Report Period Beginning: 01/01/13 Ending: 12/31/13

**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		Skilled (SNF)			1
2	49	Skilled Pediatric (SNF/PED)	49	17,885	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	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	5,824	7,164		12,988	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,824	7,164		12,988	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.62%

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  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 07/08/1968

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name &amp; ID Number

Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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
	<b>A. General Services</b>										
1	Dietary	158,296	11,737	3,868	173,901		173,901		173,901		1
2	Food Purchase		98,239		98,239		98,239	(1,767)	96,472		2
3	Housekeeping	39,695	11,225		50,920		50,920		50,920		3
4	Laundry	32,780	6,037		38,817		38,817		38,817		4
5	Heat and Other Utilities										5
6	Maintenance	58,081	18,032	72,168	148,281		148,281		148,281		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	288,852	145,270	76,036	510,158		510,158	(1,767)	508,391		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	701,601	49,931	24,214	775,746		775,746		775,746		10
10a	Therapy										10a
11	Activities	45,189	1,644	218	47,051		47,051		47,051		11
12	Social Services	31,765	11	1,773	33,549		33,549		33,549		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	778,555	51,586	26,205	856,346		856,346		856,346		16
	<b>C. General Administration</b>										
17	Administrative	70,896	9,056	21,393	101,345	(2,512)	98,833	(35,573)	63,260		17
18	Directors Fees			6,400	6,400		6,400		6,400		18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			3,915	3,915		3,915		3,915		20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			247,383	247,383	(37,834)	209,549		209,549		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,993	78,993	(28,244)	50,749		50,749		26
27	Other (specify):* <b>Bad Debt</b>			9,762	9,762		9,762	(9,762)			27
28	<b>TOTAL General Administration</b>	70,896	9,056	367,846	447,798	(68,590)	379,208	(45,335)	333,873		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,138,303	205,912	470,087	1,814,302	(68,590)	1,745,712	(47,102)	1,698,610		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 &amp; ID Number

Elizabeth Nursing Home

#0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			123,119	123,119	(71,551)	51,568	(3,670)	47,898			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,114	3,114		3,114	(3,114)				32
33	Real Estate Taxes			51,300	51,300	(34,074)	17,226	(3,221)	14,005			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			177,533	177,533	(105,625)	71,908	(10,005)	61,903			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			124,428	124,428		124,428		124,428			42
43	Other (specify):* <b>Assisted Living</b>	207,332	92,144	84,382	383,858	174,215	558,073		558,073			43
44	<b>TOTAL Special Cost Centers</b>	207,332	92,144	208,810	508,286	174,215	682,501		682,501			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,345,635	298,056	856,430	2,500,121		2,500,121	(57,107)	2,443,014			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: 01/01/13

Ending: 12/31/13

**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	(1,767)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(17,802)	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	(3,114)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,221)	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	(9,762)	27		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	(21,441)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (57,107)</b>		<b>\$</b>	<b>30</b>

**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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (57,107)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending machine revenue/activity	\$ (566)	17	1
2	Clinic Building Depreciation	(3,611)	30	2
3	ALU Land Improvements Depreciation	(59)	30	3
4	Miscellaneous	(17,205)	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	<b>Total</b>		(21,441)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elizabeth Nursing Home# 0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,767)	0	0	0	0	0	0	0	0	0	0	(1,767)	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	<b>TOTAL General Services</b>	<b>(1,767)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,767)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(35,573)	0	0	0	0	0	0	0	0	0	0	(35,573)	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):*	(9,762)	0	0	0	0	0	0	0	0	0	0	(9,762)	27
28	<b>TOTAL General Administration</b>	<b>(45,335)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(45,335)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(47,102)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(47,102)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elizabeth Nursing Home# 0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(3,670)	0	0	0	0	0	0	0	0	0	0	(3,670)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,114)	0	0	0	0	0	0	0	0	0	0	(3,114)	32
33	Real Estate Taxes	(3,221)	0	0	0	0	0	0	0	0	0	0	(3,221)	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	<b>TOTAL Ownership</b>	<b>(10,005)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(10,005)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(57,107)	0	0	0	0	0	0	0	0	0	0	(57,107)	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

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 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	<b>Total</b>			\$			\$	\$ *	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:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	Darlene Read	Shareholder	Board Member	0.06		1.5	0.04	Director Fees	\$ 1,200	1
2	Nancy Walker	Shareholder	Board Member	0.01		1.5	0.04	Director Fees	1,100	2
3	Marvin Wurster	Shareholder	Board Member	0.06		1.5	0.04	Director Fees	800	3
4	Ken Haas	Shareholder	Board Member	0.03		1.5	0.04	Director Fees	550	4
5	Ted Krohmer	Shareholder	Board Member	0.02		1.5	0.04	Director Fees	600	5
6	Wayne Trost	Shareholder	Board Member	0.02		1.5	0.04	Director Fees	450	6
7	Carol Rayhorn	Shareholder	Board Member	0.04		1.5	0.04	Director Fees	600	7
8	Donald Brudi	Shareholder	Board Member	0.01		1.5	0.04	Director Fees	600	8
9	Clark Gerleman	Shareholder	Board Member	0.01		1.5	0.04	Director Fees	500	9
10	Karen Wilson	Administrator	Administrator	0.00		40	100.00	Compensation	43,108	10
11										11
12										12
13								TOTAL	\$ 49,508	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:

01/01/13

Ending: 12/31/13

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

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
	<b>Working Capital</b>															
6																
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$			\$					
	<b>B. Non-Facility Related*</b>															
10	Shareholder Loans	X		Assisted Living Facility	Various	Various	1,438,979	1,395,591	2/1/32	5.5000	84,382					
11	Elizabeth State Bank		X	Clinic Building	\$1,050.90	10/15/06	140,000	83,480	7/17/16	1.25/5.28	3,114					
12	Shareholder Loans	X		Operations	Various	Various	130,000	130,000	2/1/32	4.7500						
13																
14	<b>TOTAL Non-Facility Related</b>				\$1,050.90		\$ 1,708,979	\$ 1,609,071			\$ 87,496					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,708,979	\$ 1,609,071			\$ 87,496					

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.		\$	<u>56,000</u>		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.)		\$	<u>56,300</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>300</u>		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>51,000</u>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>51,300</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>50,231</u>	8		
	2009	<u>49,739</u>	9		
	2010	<u>52,031</u>	10		
	2011	<u>54,231</u>	11		
	2012	<u>56,300</u>	12		
				<b>FOR BHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2012 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

**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.**



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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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:

01/01/13 Ending:

12/31/13

**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?  (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).

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>1967</u>	<u>\$ 5,275</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 5,275</b>	3

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	49	1985	1985	\$ 151,186	\$	19	\$	\$	\$ 151,186	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Retiling Floor		1986	754		19			754	9
10	Door and Wall Guards		1986	1,063		19			1,063	10
11	B-Label Fire Door		1987	481	15	31.5	15		406	11
12	Rooftop Heat/Cool unit		1987	4,992	158	31.5	158		4,162	12
13	Service Entrance Exit Door		1988	810	26	31.5	26		658	13
14	Windows		1988	12,528	398	31.5	398		10,127	14
15	Retiling Floors		1989	977	31	31.5	31		761	15
16	Vinyl Siding		1989	1,056	27	31.5	27		656	16
17	Front Entrance /Exit Door		1989	860	176	31.5	176		4,236	17
18	Rooftop Heat/Cool unit		1989	5,555	34	31.5	34		813	18
19	Reroof East, North & West		1990	49,329	1,566	31.5	1,566		36,149	19
20	Roof (East & West)		1992	8,194	260	31.5	260		5,592	20
21	Remodel Computer Office		1992	5,872	186	31.5	186		4,005	21
22	Center Structure Roof		1996	7,950	204	39	204		3,500	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		9,525	25
26	Exterior Remodel		1997	20,031	507	39.5	507		8,368	26
27	NH Hand Rail		1998	8,483	215	39.5	215		3,328	27
28	Cast Iron Tub		1998	1,482	38	39.5	38		582	28
29	NH Addition		1998	97,742	2,474	39.5	2,474		38,354	29
30	Screen Door System		1999	425	11	39.5	11		156	30
31	140K Heating / Air Conditioning		2000	3,824	98	39	98		1,320	31
32	Energy Efficient Lighting / Outside Lighting		2000	13,621	350	39	350		4,700	32
33	Koehler Utility Sink		2002	667		7			667	33
34	Tile Project - Dining Room		2003	2,113	67	31.5	67		704	34
35	AO Smith Holding Tank		2004	1,324		7			1,324	35
36	Flooring Nurses Station		2004	2,322	74	31.5	74		667	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 &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Ceiling Lights - NH	2004	\$ 484	\$ 15	31.5	\$ 15	\$	\$ 139	37
38	Suspended Ceiling - Hallway	2004	4,765	151	31.5	151		1,368	38
39	Carpet / Flooring	2005	1,972	63	31.5	63		556	39
40	Sign	2005	551		7			551	40
41	Kitchen Fire Supression System	2005	1,200	38	31.5	38		319	41
42	Telephone Wiring	2005		12	31.5	12			42
43	Door Security System	2006	11,934	306	39	306		2,282	43
44	Shelves / Cabinets - Activity Room	2006	4,020		7			4,020	44
45	Garbage Shed	2006	1,437	37	39	37		275	45
46	Fire System	2006	20,553	527	39	527		3,931	46
47	Carbon Monoxide Detecors	2007	570	57	10	57		394	47
48	Boilers	2007	24,648	632	20	632		4,819	48
49	Garbage Disposal	2007	1,001		5			1,001	49
50	Sewer Line	2007	32,350	1,617	20	1,617		10,109	50
51	Flooring-Halls	2007	793	40	20	40		248	51
52	Dumpster	2007	1,169	117	10	117		711	52
53	Vinyl Flooring & Installation	2007	472	47	10	47		283	53
54	Kitchen Sewer Replacement	2008	6,568	328	20	328		1,943	54
55	Rooftop Airconditioners	2008	11,851	1,185	10	1,185		6,420	55
56	Corridor Door	2008	1,262	126	10	126		673	56
57	Exit Lights	2009	2,834	283	10	283		1,228	57
58	Roof Repair Gazebo	2011	580	58	10	58		130	58
59	Roof Repair	2012	13,267	1,327	10	1,327		2,322	59
60	Roof	2012	15,540	1,554	10	1,554		2,330	60
61	Spray Fire Protection (exposed steel beams - upstairs)	2012	13,792	1,379	10	1,379		2,068	61
62	Penthouse(Upstairs Remodel)change stair exit (walls, doors, etc.)	2012	23,788	1,189	20	1,189		1,685	62
63	Electrical (part of penthouse (upstairs) remodel	2012	2,199	147	15	147		195	63
64	Sprinkler System	2013	59,458	1,982	15	1,982		1,982	64
65	Roof over Entry	2013	404	20	10	20		20	65
66	Bathroom Repairs	2013	3,691	123	15	123		123	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 702,198	\$ 20,852		\$ 20,852	\$	\$ 358,491	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 702,198	\$ 20,852		\$ 20,852	\$	\$ 358,491	1
2	Leasehold Improvements prior to 1981		119,177		10			119,177	2
3	3 Comm Smoke Detectors	1982	603		15			603	3
4	Air Conditioner	1982	931		15			931	4
5	Roof - South Wing	1983	10,500		15			10,500	5
6	8 - Triple Pane Windows	1984	5,131		18			5,131	6
7	15 Triple Pane Windows	1985	9,124		18			9,124	7
8	Thermiser Vent Control System	1985	2,927		19			2,927	8
9	Office Vision Panels	1985	910		19			910	9
10									10
11									11
12	Land Improvements prior to 1981		939		10			939	12
13	Landscaping, tiling, sidewalk	1996	3,143		19			3,143	13
14	Landscaping - shrubs & gravel	1988	850		15			850	14
15	Sidewalks & Landscaping	1990	1,845		15			1,845	15
16	Seal Coat Parking Lot	1990	3,500		15			3,500	16
17	Landscaping	1998	995		15			995	17
18	Tile Work	1998	1,263		15			1,263	18
19	Landscaping	1999	1,185	60	15	60		1,185	19
20	Pavement Work	2001	1,840	123	15	123		1,534	20
21	Tree	2001	450	30	15	30		375	21
22	Shrubs and Landscaping Rock	2006	618	41	15	41		310	22
23	Parking Lot	2006	64,828	4,322	15	4,322		32,415	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)		\$ 932,957	\$ 25,428		\$ 25,428	\$	\$ 556,148	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 203,237	\$ 17,881	\$ 17,881	\$		\$ 153,708	71
72	Current Year Purchases	13,897	788	788			788	72
73	Fully Depreciated Assets	311,780					311,780	73
74								74
75	TOTALS	\$ 528,914	\$ 18,669	\$ 18,669	\$		\$ 466,276	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)	\$ 1,467,146	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,097	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,097	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)	\$ 1,022,424	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	\$ 2,743,594	\$ 71,551	\$ 754,384	86
87	Building - Clinic	140,816	3,611	25,726	87
88	Land Imp - Assisted Living	6,032	59	5,591	88
89	Equipment - Assisted Living	65,198	3,801	53,570	89
90					90
91	TOTALS	\$ 2,955,640	\$ 79,022	\$ 839,271	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:

01/01/13

Ending: 12/31/13

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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	<b>TOTAL</b>		\$	\$	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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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	<b>TOTAL</b>			\$		\$	\$		\$	14	

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

Facility Name & ID Number Elizabeth Nursing Home# 0008300Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 50,610	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	144,157		3
4	Supply Inventory (priced at )	7,385		4
5	Short-Term Investments	11,716		5
6	Prepaid Insurance	10,716		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	8,746		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 233,330	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	3,735,911		14
15	Leasehold Improvements, at Historical Cost	87,489		15
16	Equipment, at Historical Cost	594,113		16
17	Accumulated Depreciation (book methods)	(1,861,695)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,561,093	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,794,423	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 35,409	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	185,592		29
30	Accrued Salaries Payable	139,190		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,804		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000		32
33	Accrued Interest Payable	17,340		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Provider Assessment Fees</u>	39,904		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 474,239	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,423,479		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deferred Income taxes</u>	8,746		43
44	<u>Assisted Living Deposits</u>	28,774		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,460,999	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,935,238	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 859,185	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,794,423	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 910,669	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 910,669	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(47,814)	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	(3,670)	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)	\$ (51,484)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 859,185	24 *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,414,671	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,414,671	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,767	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	566	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,333	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	800	24
25	Interest and Other Investment Income***	5	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 805	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Clinic Rent</u>	17,802	28
28a	<u>Miscellaneous</u>	16,696	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 34,498	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,452,307	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	509,471	31
32	Health Care	852,537	32
33	General Administration	453,505	33
<b>B. Capital Expense</b>			
34	Ownership	177,533	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	124,428	36
<b>D. Other Expenses (specify):</b>			
37	<u>Assisted Living</u>	382,647	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,500,121	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(47,814)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (47,814)	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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:

01/01/13

Ending:

12/31/13

**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	1,912	2,080	\$ 46,700	\$ 22.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,428	8,826	200,232	22.69	3
4	Licensed Practical Nurses	3,840	4,184	80,681	19.28	4
5	CNAs & Orderlies	33,820	35,701	374,920	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,673	4,032	45,189	11.21	10
11	Social Service Workers	2,100	2,276	31,765	13.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,916	14,859	158,296	10.65	15
16	Dishwashers					16
17	Maintenance Workers	3,950	4,294	58,081	13.53	17
18	Housekeepers	3,683	3,982	39,695	9.97	18
19	Laundry	3,072	3,292	32,780	9.96	19
20	Administrator	1,752	1,840	43,444	23.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,457	1,602	26,520	16.55	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) <u>Assisted Living</u>	17,311	18,376	207,332	11.28	33
34	TOTAL (lines 1 - 33)	98,914	105,344	\$ 1,345,635 *	\$ 12.77	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	79	\$ 3,868	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant	24	353	38
39	Pharmacist Consultant	46	1,275	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	4	218	44
45	Social Service Consultant	7	398	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	160	\$ 6,112	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	
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$	
Description			Amount			Less: Public Relations Expense ( )		
			\$			Non-allowable advertising ( )		
						Yellow page advertising ( )		
						TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$			\$		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount	Amount	Description	Line #	Amount	Amount	
		\$	\$				Out-of-State Travel	
							\$	
							In-State Travel	
							Seminar Expense	
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	
							\$	

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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 \$3,339
- (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. \$ 124,428  
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. \$ 1,767
- (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.