FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0052365

Facility Name: Green Acres Hlthcare & Rehab

Address: 15 West Wasson Road (Number) Amboy (City) 61310 (Zip Code)

County: Lee

Telephone Number: (815)857-2550 **Fax #** (815)857-4016

HFS ID Number:

Date of Initial License for Current Owners: 06/01/13

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 06/01/13 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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 N/A

	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	97	Skilled (SNF)	97	20,758	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	20,758	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		235	1,454	1,689	8
9	SNF/PED					9
10	ICF	5,146	3,960	1	9,107	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,146	4,195	1,455	10,796	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.01%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 06/01/13

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/13 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 1,454

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	81,885	4,181	2,979	89,045		89,045		89,045			1
2	Food Purchase		75,931		75,931		75,931	(599)	75,332			2
3	Housekeeping	34,384	18,425		52,809		52,809	36	52,845			3
4	Laundry	26,067			26,067		26,067		26,067			4
5	Heat and Other Utilities			31,860	31,860		31,860	478	32,338			5
6	Maintenance	16,933	39,138	3,535	59,606		59,606	1,454	61,060			6
7	Other (specify):*											7
8	TOTAL General Services	159,269	137,675	38,374	335,318		335,318	1,369	336,687			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	544,347	18,804		563,151		563,151		563,151			10
10a	Therapy	28,978			28,978		28,978		28,978			10a
11	Activities	17,450	4,364		21,814		21,814		21,814			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	590,775	23,168	1,200	615,143		615,143		615,143			16
	C. General Administration											
17	Administrative	43,930		33,333	77,263		77,263	(14,202)	63,061			17
18	Directors Fees											18
19	Professional Services			21,896	21,896		21,896	454	22,350			19
20	Dues, Fees, Subscriptions & Promotions			6,838	6,838		6,838	(1,220)	5,618			20
21	Clerical & General Office Expenses	76,876		34,449	111,325		111,325	19,828	131,153			21
22	Employee Benefits & Payroll Taxes			139,001	139,001		139,001	700	139,701			22
23	Inservice Training & Education											23
24	Travel and Seminar			460	460		460	141	601			24
25	Other Admin. Staff Transportation			3,234	3,234		3,234	678	3,912			25
26	Insurance-Prop.Liab.Malpractice			29,865	29,865		29,865	244	30,109			26
27	Other (specify):* Mgmt Alloc of Benefi							5,777	5,777			27
28	TOTAL General Administration	120,806		269,076	389,882		389,882	12,400	402,282			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	870,850	160,843	308,650	1,340,343		1,340,343	13,769	1,354,112			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Green Acres Hlthcare & Rehab #0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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			24,217	24,217		24,217	(6,483)	17,734			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,100	1,100		1,100	(1,100)				32
33	Real Estate Taxes			23,631	23,631		23,631	23,536	47,167			33
34	Rent-Facility & Grounds			91,000	91,000		91,000	(91,000)				34
35	Rent-Equipment & Vehicles			1,400	1,400		1,400	423	1,823			35
36	Other (specify):*											36
37	**TOTAL Ownership**			141,348	141,348		141,348	(74,624)	66,724			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,891	169,883	223,774		223,774		223,774			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,703	83,703		83,703		83,703			42
43	Other (specify):* **Non-Allowable Cos**			19,097	19,097		19,097	(19,097)				43
44	**TOTAL Special Cost Centers**		53,891	272,683	326,574		326,574	(19,097)	307,477			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	870,850	214,734	722,681	1,808,265		1,808,265	(79,952)	1,728,313			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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	22,464	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(56,778)	30		9
10	Interest and Other Investment Income	(1,100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(400)	43		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	(5,884)	43		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	(12,878)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,576)		$	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)	(25,376)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (25,376)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (79,952)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Green Acres Hlthcare & Rehab

ID# 0052365

Report Period Beginning: 06/01/13

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (3,018)	43	1
2	X Ray Expense Med A	(1,149)	43	2
3	Managed Care Cost	(8,646)	43	3
4	Lobbying Fees	(1,305)	20	4
5	Repairs & Maintenance	1,240	6	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**	(12,878)		49

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 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	30	Depreciation	$	Green Acres Property LLC		$ 49,011	$ 49,011	1
2	V	33	Real Estate Taxes		Green Acres Property LLC		22,465	22,465	2
3	V	34	Rent	113,465	Green Acres Property LLC			(113,465)	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			$ 113,465			$ 71,476	$ * (41,989)	14

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

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 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)	
15	V	2	Food	$	SW Financial Services Company	100.00%	$ 101	$ 101	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	36	36	16
17	V	5	Utilities		SW Financial Services Company	100.00%	478	478	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	214	214	18
19	V	17	Administrative	33,333	SW Financial Services Company	100.00%	19,131	(14,202)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	454	454	20
21	V	20	Dues, Fees, Subscriptions		SW Financial Services Company	100.00%	85	85	21
22	V	21	Clerical & General Office Exp		SW Financial Services Company	100.00%	19,828	19,828	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	141	141	23
24	V	25	Other Admin Staff Transport		SW Financial Services Company	100.00%	678	678	24
25	V	26	Insurance-Prop, Liab & Malpr		SW Financial Services Company	100.00%	244	244	25
26	V	27	Other Mgmt Alloc of Benefits		SW Financial Services Company	100.00%	5,777	5,777	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	1,284	1,284	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	1,071	1,071	28
29	V	35	Rent		SW Financial Services Company	100.00%	423	423	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 33,333			$ 49,945	$ * 16,612	39

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

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	Albert Milstein	35.81	Cahokia Nursing and Rehab	Cahokia	Shabbona Supportive	Shabbona	Supportive Living	1
2	Sheldon Wolfe	35.81	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Jeremy Amster	3	Shabbona Healthcare Center	Shabbona	SW Financial	Skokie	Bookkeeping/	3
4	David Zuckerman	10			Services Co.		Management Comp.	4
5	Suzanne Koenig	15.38	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6			Oregon Living & Rehabilitation, LLC	Oregon	* SFO Associates	Skokie	Finance Company	6
7			Green Acres Healthcare Rehab Center, LLC	Amboy				7
8					* This entity only relates to Shabbona Healthcare Center,			8
9					Franklin Grove Living & Rehab, and Oregon Living & Rehab			9
10			Beauvais Manor Healthcare and Rehab	St. Louis, MO				10
11			Hillside Manor Healthcare and Rehab	St. Louis, MO	Groves Community	Independence, MO	Hospice	11
12			Rancho Manor Healthcare and Rehab	Florissant, MO	Hospice			12
13			Rosewood Health & Rehab	Independence, MO	Forest View Senior	Independence, MO	Independent	13
14			Seasons Care Center	Kansas City, MO	Residences		Living	14
15					White Oak Living	Independence, MO	Residential	15
16					Center		Care	16
17								17
18					Seasons Day Services	Kansas City, MO	Adult Day Care	18
19					Program LLC			19
20								20
21					Cahokia Building LLC	Cahokia	Real Estae	21
22					Caseyville Property LL	Caseyville	Real Estate	22
23					Shabbona Building	Shabbona	Real Estate	23
24					Associates LLC			24
25								25
26					Franklin Grove	Franklin Grove	Real Estate	26
27					Associates			27
28					Oregon Associates	Oregon	Real Estate	28
29								29
30					Green Acres Property	Amboy	Real Estate	30

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	Sheldon Wolfe	President	Administrative	35.81	See Schedule 7A	2.5	13.33	Salary	$ 11,967	L17,C7	1
2											2
3											3
4											4
5											5
6			Note: Mr. Wolfe works in excess of 40 hours per week.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,967		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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 2/31/2013

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 [X] NO [ ]

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

Name of Related Organization: SW Financial Services Co.
Street Address: 7434 N. Skokie Blvd
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	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	2	Food	Bed Days Available	633,958	12	$ 3,076	$	20,758	$ 101	1
2	3	Housekeeping	Bed Days Available	633,958	12	1,102		20,758	36	2
3	5	Utilities	Bed Days Available	633,958	12	14,584		20,758	478	3
4	6	Maintenance-Salary	Bed Days Available	633,958	12	6,537		20,758	214	4
5	19	Professional Services-Legal	Bed Days Available	633,958	12	13,851		20,758	454	5
6	20	Dues, Fees, Subscriptions	Bed Days Available	633,958	12	2,583		20,758	85	6
7	21	Clerical & General Office-Salary	Bed Days Available	633,958	12	522,868	522,868	20,758	17,121	7
8	21	Clerical & General Office-Other	Bed Days Available	633,958	12	82,658		20,758	2,707	8
9	24	Travel & Seminar	Bed Days Available	633,958	12	4,312		20,758	141	9
10	25	Other Admin Staff Transport	Bed Days Available	633,958	12	20,693		20,758	678	10
11	26	Insurance-Prop, Liab, Malp	Bed Days Available	633,958	12	7,467		20,758	244	11
12	27	Other-Mgmt Allocation	Bed Days Available	633,958	12	176,429		20,758	5,777	12
13	33	Real Estate Taxes	Bed Days Available	633,958	12	32,704		20,758	1,071	13
14	35	Rent	Bed Days Available	633,958	12	12,906		20,758	423	14
15										15
16	17	Administrative - Salary	Average Hours Worked	45	12	215,400	215,400	3	11,967	16
17	17	Administrative - Salary	Average Hours Worked	45	12	128,945	128,945	3	7,164	17
18										18
19	30	Depreciation	Direct Cost	39,214					1,284	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,246,115	$ 867,213		$ 49,945	25

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	MB Bank		X	Line of Credit	Interest Only	12/15/13	100,000	100,000	12/15/23	Various		6
7	Shabbona Healthcare Center	X		Line of Credit	Varies	8/31/13	300,000	301,100	8/31/14	0.0165	1,100	7
8												8
9	TOTAL Facility Related						$ 400,000	$ 401,100			$ 1,100	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(1,100)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,100)	14
15	TOTALS (line 9+line14)						$ 400,000	$ 401,100			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** 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 Green Acres Hlthcare & Rehab **#** 0052365 **Report Period Beginning:** 06/01/13 **Ending:** 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 29,779	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.)	**2012**	$ 37,390	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,611	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,485	4
	Allocated from Mgmt Co.	1,071	
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.		$ 47,167	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008		8
	2009		9
	2010		10
	2011		11
	2012	37,390	12

RE Tax Accrual calculated by $37,390 x 1.03 = $38,512. Used $38,485.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Green Acres Hlthcare & Rehab COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0052365

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 932-2304

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-15-328-002	Long Term Care Proprety	$ 37,389.84	$ 37,389.84
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 35,417.00	$ 1,071.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,806.84	$ 38,460.84

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 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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories One

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. [X] (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).

N/A

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	Resident Care		2013	$ 51,227	1
2					2
3	TOTALS			$ 51,227	3

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	97		2013		$ 802,561	$ 11,704	40	$ 10,032	$ (1,672)	$ 10,032	4
5											5
6											6
7	Allocated from Management Co.				13,087			374	374	6,975	7
8											8
	Improvement Type**										
9	Roof			2013	31,150	260	40	389	130	389	9
10	Gutters & Soffit			2013	21,170	132	40	265	132	265	10
11	Walk-in cooler/freezer combo			2013	20,561	214	40	257	43	257	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	Allocated from SW Financial Services Co. - Leasehold Improvements			1995	1,465			72	72	1,465	26
27	Allocated from SW Financial Services Co. - Leasehold Improvements			1996	244			12	12	214	27
28	Allocated from SW Financial Services Co. - Leasehold Improvements			1997	283			14	14	268	28
29	Allocated from SW Financial Services Co. - Leasehold Improvements			1998	242			12	12	190	29
30	Allocated from SW Financial Services Co. - Leasehold Improvements			1999	671			34	34	473	30
31	Allocated from SW Financial Services Co. - Leasehold Improvements			2005	1,389			69	69	590	31
32	Allocated from SW Financial Services Co. - Leasehold Improvements			2007	786			39	39	255	32
33	Allocated from SW Financial Services Co. - Leasehold Improvements			2009	1,641			82	82	369	33
34	Allocated from SW Financial Services Co. - Leasehold Improvements			2013	876			22	22	22	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	$	$	$	$		$	71
72	Current Year Purchases	315,506	9,491	3,092	(6,399)	5	3,092	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.	4,222		88	88		3,452	74
75	TOTALS	$ 319,728	$ 9,491	$ 3,180	$ (6,311)		$ 6,544	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	Patient Transport	Ford E350	2013	$ 24,159	$ 2,416	$ 2,416	$	5	$ 2,416	76
77	Allocated from Management Co			2,325		465	465		1,628	77
78										78
79										79
80	TOTALS			$ 26,484	$ 2,416	$ 2,881	$ 465		$ 4,044	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)	$	1,293,565	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	24,217	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	17,734	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(6,484)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	32,352	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ N/A	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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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:	N/A			$			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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 1,400 Description: Janssen AG Services
    (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	Allocated from SW Financial Services		$	$ 423	17
18					18
19					19
20					20
21	TOTAL		$	$ 423	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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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

It is the policy of this facility to only hire certified nurses aides.

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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	1,071	$ 77,144	$	1,071	$ 77,144	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		197	14,184		197	14,184	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,091	78,555		1,091	78,555	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				48,341		48,341	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					5,550		5,550	12
13	Other (specify):									13
14	TOTAL			$	2,359	$ 169,883	$ 53,891	2,359	$ 223,774	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 Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 74,463	$ 74,463	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,191,328	1,191,328	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,411	35,411	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	2,323	2,323	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,303,525	$ 1,303,525	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		51,227	13
14	Buildings, at Historical Cost		815,649	14
15	Leasehold Improvements, at Historical Cost	74,121	80,477	15
16	Equipment, at Historical Cost	55,068	346,212	16
17	Accumulated Depreciation (book methods)	(24,217)	(32,352)	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)**	$ 104,972	$ 1,261,213	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,408,497	$ 2,564,738	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 55,852	$ 55,852	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,172	10,172	28
29	Short-Term Notes Payable	401,100	401,100	29
30	Accrued Salaries Payable	135,257	135,257	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,918	22,918	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,485	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	629,101	1,638,002	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,254,400	$ 2,301,786	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,254,400	$ 2,301,786	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 154,097	$ 262,952	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,408,497	$ 2,564,738	48

***(See instructions.)**

XV. Balance Sheet

	Ln 9 - Other Current Assets	Operating	After Consolidation
3015	EMPLOYEE PAYROLL ADVANC	2,262.00	2,262.00
7052	PRIOR OWNER BALANCE	61.00	61.00
	Total	**2,323**	**2,323**

	Ln-36 Other Current Liabilities	Operating	After Consolidation
2073	DUE FROM STATE - INTEREST	(2,041.00)	(2,041.00)
3029	REIMBURSEMENT DUE	(5,000.00)	(5,000.00)
7055	INSURANCE PREMIUMS PAYAE	3,714.00	3,714.00
7165	DUE - PRO-RATION LIABILITY	44,180.00	44,180.00
7310	ACCRUED EXPENSES	97,149.00	97,149.00
7810	MEMBER LOANS	375,000.00	375,000.00
8811	DUE/FROM GREEN ACRES PROI	116,099.00	-
9020	Undistributed Taxable Income	-	1,125,000.00
	Total	**629,101**	**1,638,002**

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	154,097		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	( )		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)**	$ 154,097		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)**	$ 154,097		24 *

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

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	$ 1,904,032	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,904,032	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	53,600	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 53,600	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,041	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,041	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Patient Fund Liability	2,689	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,689	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,962,362	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	335,318	31
32	Health Care	615,143	32
33	General Administration	389,882	33
	B. Capital Expense		
34	Ownership	141,348	34
	C. Ancillary Expense		
35	Special Cost Centers	242,871	35
36	Provider Participation Fee	83,703	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,808,265	40
41	**Income before Income Taxes (line 30 minus line 40)****	154,097	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 154,097	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 726,117	44
45	Private Pay - Net Inpatient Revenue	512,389	45
46	Medicare - Net Inpatient Revenue	664,234	46
47	Other-(specify) Hospice	1,292	47
48	Other-(specify)	-	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,904,032	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.**

^ **LLC Members are cash basis taxpayers**

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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	840	1,100	$ 40,877	$ 37.16	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,317	2,457	76,510	31.14	3
4	Licensed Practical Nurses	4,624	4,919	144,584	29.39	4
5	CNAs & Orderlies	19,207	20,509	282,376	13.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	866	1,019	28,978	28.44	8
9	Activity Director					9
10	Activity Assistants	1,247	1,274	17,450	13.70	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	928	960	14,141	14.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,159	5,658	67,744	11.97	15
16	Dishwashers					16
17	Maintenance Workers	984	1,064	16,933	15.91	17
18	Housekeepers	3,154	3,398	34,384	10.12	18
19	Laundry	2,275	2,408	26,067	10.83	19
20	Administrator	960	960	43,930	45.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,795	4,013	76,876	19.16	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)					33
34	TOTAL (lines 1 - 33)	46,356	49,739	$ 870,850 *	$ 17.51	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	Monthly	$ 2,979	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 4,179		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bernadean McCoy	Administrator	0	$ 43,930
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 43,930

B. Administrative - Other

Description	Amount
Management Fees	$ 33,333
(Eliminated on Sch V Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 33,333

C. Professional Services

Vendor/Payee	Type	Amount
Unemployment Consultants	U-E Consultants	$ 315
McGladrey LLP	Accounting	18,926
Allen Lefkovitz & Assoc., P.C.	Legal	1,613
Polsinelli Shughart	Legal	1,042
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,896

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,261
Unemployment Compensation Insurance	21,268
FICA Taxes	69,555
Employee Health Insurance	30,042
Employee Meals	700
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	1,875
TOTAL (agree to Schedule V, line 22, col.8)	$ 139,701

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

Description	Line #	Amount
N/A		$
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 188)	
Patient Background Checks	2,255
Miscellaneous Dues & Permits	758
Miscellaneous Inspections & Licenses	108
Allocated from Home Office	85
Illinois Council for Long Term Care	3,717
Less : Lobbying Expense	(1,305)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,618

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	460
Seminar Expense	
Allocated from Home Office	141
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 601

**See instructions.

Green Acres Healthcare Rehab Center
0052365
12/31/13

Schedule 21C

XIX. SUPPORT SCHEDULE
C. Professional Services

Allen Lefkovitz & Assoc., P.C.	1,613
Polsinelli Shughart	1,042
Total Legal	2,655
Unemployment Consultants	315
McGladrey LLP	18,926
Total (agree to Schedule V, line 19, column 3)	21,896
Allocation from Home Office	
-Legal	81
-Accounting	373
Total (agree to Schedule V, line 19, column 8)	22,350

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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											N/A		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Green Acres Hlthcare & Rehab # 0052365 Report Period Beginning: 06/01/13 Ending: 12/31/2013

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? **Yes**
If YES, give association name and amount. **IL Council for Long Term Care -$3,717**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **N/A**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,180** Line **10**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **83,703**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **700** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.