

		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.

<p>I. IDPH License ID Number: <u>0025239</u></p> <p>Facility Name: <u>ROLLING HILLS MANOR</u></p> <p>Address: <u>3615 16TH STREET</u> <u>ZION</u> <u>60099</u> Number City Zip Code</p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>(847)746-8382</u> Fax # <u>(847)746-3545</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>9-01-1979</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501C(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>JAMES S. STEFO, SR.</u> Telephone Number: <u>(847)456-6681</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501C(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>11/01/2012</u> to <u>10/31/2013</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>JAMES S. STEFO, SR.</u> (Title) <u>EXECUTIVE DIRECTOR</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="center"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JAMES S. STEFO, SR.</u> (Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
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IRS Exemption Code <u>501C(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JAMES S. STEFO, SR.</u> (Title) <u>EXECUTIVE DIRECTOR</u>																												
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																												

Facility Name & ID Number ROLLING HILLS MANOR

0025239 Report Period Beginning: 11/01/2012 Ending: 10/31/2013

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 _____

	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	115	Skilled (SNF)	115	41,975	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	115	TOTALS	115	41,975	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,918	8,158	14,254	37,330	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,918	8,158	14,254	37,330	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.93%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 9 / 01 / 1979

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

YES Date 9 / 01 / 1979 NO

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

YES NO If YES, enter number of beds certified 115 and days of care provided 14,254

Medicare Intermediary WPS MEDICARE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/2013 Fiscal Year: 10/31/2013

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

Facility Name & ID Number **ROLLING HILLS MANOR** # **0025239** Report Period Beginning: **11/01/2012** Ending: **10/31/2013**

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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	372,927	40,367	56,114	469,408		469,408		469,408		1
2	Food Purchase		251,429		251,429	(26,268)	225,161	(2,342)	222,819		2
3	Housekeeping	283,937	59,278		343,215		343,215		343,215		3
4	Laundry	195,444	21,839	12,552	229,835		229,835		229,835		4
5	Heat and Other Utilities			219,112	219,112		219,112		219,112		5
6	Maintenance	225,140	12,073	95,941	333,154		333,154		333,154		6
7	Other (specify):* Rolling Hills Place			907,840	907,840		907,840	(907,840)			7
8	TOTAL General Services	1,077,448	384,986	1,291,559	2,753,993	(26,268)	2,727,725	(910,182)	1,817,543		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	4,151,449	329,116	855,553	5,336,118	(657,546)	4,678,572		4,678,572		10
10a	Therapy			1,544,146	1,544,146		1,544,146		1,544,146		10a
11	Activities	124,823	6,389	7,321	138,533		138,533		138,533		11
12	Social Services	105,557	1,495		107,052		107,052		107,052		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Rolling Hills Place			520,366	520,366		520,366	(520,366)			15
16	TOTAL Health Care and Programs	4,381,829	337,000	2,942,386	7,661,215	(657,546)	7,003,669	(520,366)	6,483,303		16
	C. General Administration										
17	Administrative	218,593		57,192	275,785		275,785	(57,192)	218,593		17
18	Directors Fees			16,400	16,400		16,400		16,400		18
19	Professional Services			70,715	70,715		70,715		70,715		19
20	Dues, Fees, Subscriptions & Promotions			59,596	59,596		59,596	(19,366)	40,230		20
21	Clerical & General Office Expenses	441,531	58,877	213,649	714,057		714,057	(41,936)	672,121		21
22	Employee Benefits & Payroll Taxes			1,111,979	1,111,979	26,268	1,138,247	(10,609)	1,127,638		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,264	10,264		10,264		10,264		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			92,286	92,286		92,286		92,286		26
27	Other (specify):* Rolling Hills Place				725,086		725,086	(725,086)			27
28	TOTAL General Administration	660,124	58,877	1,632,081	3,076,168	26,268	3,102,436	(854,189)	2,248,247		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,119,401	780,863	5,866,026	13,491,376	(657,546)	12,833,830	(2,284,737)	10,549,093		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.

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
	D. Ownership										
30	Depreciation			261,936	261,936		261,936	13,728	275,664		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			104,722	104,722		104,722	(63,853)	40,869		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Rolling Hills Place				438,573		438,573	(438,573)			36
37	TOTAL Ownership			366,658	805,231		805,231	(488,698)	316,533		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Participation Fee and Bed Tax			202,537	202,537		202,537		202,537		42
43	Other :*(specify) Prescripton Drugs					657,546	657,546		657,546		43
44	TOTAL Special Cost Centers			202,537	202,537	657,546	860,083		860,083		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,119,401	780,863	6,435,221	14,499,144		14,499,144	(2,773,435)	11,725,709		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,609)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,728	30		9
10	Interest and Other Investment Income	(63,853)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,342)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,192)	17		24
25	Fund Raising, Advertising and Promotional	(19,366)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (139,634)		\$	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	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)	(2,633,801)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,633,801)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,773,435)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	x		657,546	10:3	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 657,546		47

ROLLING HILLS MANOR

ID# 0025239

Report Period Beginning: 11/01/2012

Ending: 10/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27

28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2012

Ending:

10/31/2013

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	1
2	Food Purchase	(2,342)	0			0	0	0	0	0	0	0	(2,342)	2
3	Housekeeping	0	0			0	0	0	0	0	0	0	0	3
4	Laundry	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	5
6	Maintenance	0	0			0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	(907,840)			0	0	0	0	0	0	0	(907,840)	7
8	TOTAL General Services	(2,342)	(907,840)		0	0	0	0	0	0	0	0	(910,182)	8
	B. Health Care and Programs													
9	Medical Director	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	10
10a	Therapy	0	0			0	0	0	0	0	0	0	0	10a
11	Activities	0	0			0	0	0	0	0	0	0	0	11
12	Social Services	0	0			0	0	0	0	0	0	0	0	12
13	CNA Training	0	0			0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0			0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(520,366)			0	0	0	0	0	0	0	(520,366)	15
16	TOTAL Health Care and Programs	0	(520,366)	0	0	0	0	0	0	0	0	0	(520,366)	16
	C. General Administration													
17	Administrative	(57,192)	0			0	0	0	0	0	0	0	(57,192)	17
18	Directors Fees	0	0			0	0	0	0	0	0	0	0	18
19	Professional Services	0	0			0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(19,366)	0			0	0	0	0	0	0	0	(19,366)	20
21	Clerical & General Office Expenses	0	(41,936)			0	0	0	0	0	0	0	(41,936)	21
22	Employee Benefits & Payroll Taxes	(10,609)	0			0	0	0	0	0	0	0	(10,609)	22
23	Inservice Training & Education	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	24
25	Other Admin. Staff Transportation	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	26
27	Other (specify):*	0	(725,086)			0	0	0	0	0	0	0	(725,086)	27
28	TOTAL General Administration	(87,167)	(767,022)		0	0	0	0	0	0	0	0	(854,189)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(89,509)	(2,195,228)	0	0	0	0	0	0	0	0	0	(2,284,737)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2012

Ending:

10/31/2013

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	13,728	0			0	0	0	0	0	0	0	13,728	30
31	Amortization of Pre-Op. & Org.	0	0			0	0	0	0	0	0	0	0	31
32	Interest	(63,853)	0			0	0	0	0	0	0	0	(63,853)	32
33	Real Estate Taxes	0	0			0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	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	35
36	Other (specify):*	0	(438,573)			0	0	0	0	0	0	0	(438,573)	36
37	TOTAL Ownership	(50,125)	(438,573)	0	0	0	0	0	0	0	0	0	(488,698)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	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	39
40	Barber and Beauty Shops	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	41
42	Provider Participation Fee	0	0			0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0			0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0			0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(139,634)	(2,633,801)	0	0	0	0	0	0	0	0	0	(2,773,435)	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
Sovak American Charitable Association	100	N/A	N/A	N/A	N/A	N/A
N/A		N/A	N/A	Rolling Hills Place	Zion, Illinois	Assisted Living Facility

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Administrative Expenses	\$ 41,936			\$	\$ (41,936)	1
2	V	7 General Services	907,840				(907,840)	2
3	V	15 Healthcare and Programs	520,366				(520,366)	3
4	V	27 General Administration	725,086				(725,086)	4
5	V	36 Capital Expenses	438,573				(438,573)	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		\$ 2,633,801			\$	\$ * (2,633,801)	14

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

Facility Name & ID Number

ROLLING HILLS MANOR

0025239

Report Period Beginning:

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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	JAMES STEFO, JR.	DIRECTOR	PRESIDENT	NONE	NONE	1/2 HR.	2.00	DIR. FEE	\$ 2,400	18:3	1
2	ANNE LESAK SCOTT	DIRECTOR	VICE PRES.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,400	18:3	2
3	JANET PILCH	DIRECTOR	TREASURER	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,400	18:3	3
4	DOROTHY MITCHELL	DIRECTOR	SECRETARY	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,400	18:3	4
5	ELEANOR PETRAS	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,000	18:3	5
6	MARION STEFO	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,400	18:3	6
7	STEVE FUSEK	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,400	18:3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,400		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 ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2012

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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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2012

Ending:

10/31/2013

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	IDFA REVENUE BONDS			REFINANCING OF SERIES			\$	\$			\$	1						
2	SERIES 2000		X	1996 BONDS	\$11,800.00	6/20/2000	2,600,000	1,983,293	6/29/2030	4.1700	86,394	2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$11,800.00		\$ 2,600,000	\$ 1,983,293			\$ 86,394	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,600,000	\$ 1,983,293			\$ 86,394	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 report.		\$	NONE		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.)		\$	NONE		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	NONE		3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	NONE		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	NONE		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.)		\$	NONE		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	NONE		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	NONE	8	FOR BHF USE ONLY		
	2009	NONE	9			
	2010	NONE	10			
	2011	NONE	11			
	2012	NONE	12			
				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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 ROLLING HILLS MANOR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0025239

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____

TOTALS \$ \$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 ROLLING HILLS MANOR

0025239 Report Period Beginning:

11/01/2012 Ending:

10/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,632 B. General Construction Type: Exterior BRICK Frame N/A Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

ROLLING HILLS PLACE

68 BEDS / 60 UNITS

48,000 SQUARE FEET

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: NURSING HOME, 3 ACRES, 1979, \$ 100,763, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 3 ACRES, (blank), \$ 100,763, 3.

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**

Report Period Beginning:

11/01/2012 Ending:

10/31/2013

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	115		1979	1970	\$ 927,078	\$ 9,449	40	\$ 23,177	\$ 13,728	\$ 891,771	4
5			1979	1970	712,648	20,361	35	20,361		692,738	5
6			1992	1992	1,234,270	30,857	40	30,857		663,420	6
7			1992	1992	232,299		10			232,299	7
8			1998	1998	695,702	17,393	40	17,393		261,655	8
	Improvement Type**										
9		AIRLOCKS		1982	3,886		20			3,886	9
10		ROOF		1983	41,724		20			41,724	10
11		PLUMBING FIXTURES		1983	3,845		20			3,845	11
12		ROOF AND HEATER		1984	118,647		20			118,647	12
13		SURFACING AND DRAINAGE		1984	37,141		10			37,141	13
14		SHRUBBERY		1985	1,061		10			1,061	14
15		RAMP		1985	38,992		20			38,992	15
16		MXING VLAVE		1985	325		20			325	16
17		FENCE		1986	1,257		20			1,257	17
18		RAMP		1986	5,400		20			5,400	18
19		ROOF		1986	33,997		20			33,997	19
20		HEATING UNITS		1986	6,344		3			6,344	20
21		FLOOD DEVICE		1989	7,418		10			7,418	21
22		ELECTRIC PANELS		1989	6,354		5			6,354	22
23		HALLWAY LIGHTING		1990	8,091		10			8,091	23
24		ALARM SYSTEM		1991	6,775		10			6,775	24
25		PELLA WINDOWS		1992	4,367		100			4,367	25
26		PELLA WINDOWS		1992	3,661		5			3,661	26
27		ROOF		1993	24,500		10			24,500	27
28		PELLA WINDOWS		1993	14,624	367	20	367		14,624	28
29		ROOF		1994	24,500		10			24,500	29
30		HEATING UNITS		1994	6,987		10			6,987	30
31		WATER LINE		1994	6,820	171	20	171		6,480	31
32		PARKING LOT SURFACING		1994	4,346	217	20	217		3,517	32
33		ROOF		1995	24,800		10			24,800	33
34		HOT WATR SYSTEM		1995	18,175		10			18,175	34
35		DOOR LOCKS		1995	12,473		10			12,473	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 **ROLLING HILLS MANOR**# **0025239**

Report Period Beginning:

11/01/2012 Ending: 10/31/2013

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	CALL LIGHTING SYSTEM	1996	\$ 14,321	\$	10	\$	\$	\$ 14,321	37
38	RETAINING WALL	1996	38,975	1,949	20	1,949		34,105	38
39	OXYGEN ENVIRONMENT	1996	3,892		10			3,892	39
40	EMERGENCY GENERATOR	1996	10,089		10			10,089	40
41	CANOPIES	1997	2,490		15			2,490	41
42	KITCHEN TILING	1997	3,507		10			3,507	42
43	AIR CONDITIONING	1997	5,970		10			5,970	43
44	ROOF	1998	5,500		10			5,500	44
45	SIGN	1999	2,768	69	40	69		1,036	45
46	SIGN	1999	4,668	117	40	117		1,753	46
47	PELLA WINDOWS	1999	7,855	393	20	393		5,697	47
48	CARPETING AND WALLPAPER	2000	9,279	167	15	167		8,752	48
49	SMOKE DETECTORS	2000	12,985	485	15	485		10,172	49
50	ROOF	2000	12,585	629	20	629		8,494	50
51	SEWER EXTENSION	2000	11,480	574	20	574		7,749	51
52	SHRUBBERY	2001	2,211	147	15	147		1,839	52
53	PAINT AND WALLPAPER	2001	1,510		10			1,510	53
54	VINYL FLOORING	2001	9,602		10			9,602	54
55	CARPETING AND WALLPAPER	2001	17,556		10			17,556	55
56	HAND RAILS	2001	11,425	571	20	571		7,138	56
57	PRESSURE VALVE	2001	4,636	232	20	232		2,899	57
58	EXHAUST FANS	2001	3,994	200	20	200		2,499	58
59	CARPETING AND TILE	2002	80,772		10			80,772	59
60	HAND RAILS	2002	28,365	1,418	40	1,418		16,308	60
61	CLASSROOM FLOORS AND WALLS	2002	2,970	149	40	149		1,712	61
62	WOOD COLUMNS	2002	7,050	353	40	353		4,058	62
63	FLOOR OUTLETS	2002	4,606	230	40	230		2,646	63
64	DOOR	2002	7,360	368	40	368		4,232	64
65	VINYL FOLOORING	2003	29,600	1,420	10	1,420		29,540	65
66	DOORS	2003	6,835	342	40	342		3,594	66
67	SIDEWALKS	2003	4,352	218	40	218		2,288	67
68	SHRUBBERY	2004	5,000	500	10	500		4,750	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,642,715	\$ 89,346		\$ 103,074	\$ 13,728	\$ 3,523,694	70

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

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2012 Ending: 10/31/2013

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	
1	Totals from Page 12A, Carried Forward		\$ 4,642,715	\$ 89,346		\$ 103,074	\$ 13,728	\$ 3,523,694	1
2	CARPETING	2004	27,900	2,790	10	2,790		26,505	2
3	DOORS	2004	11,800	590	20	590		5,605	3
4	DOORS	2005	3,372	169	20	169		1,434	4
5	WALL GUARDS AND RAILS	2005	3,540	354	10	354		3,009	5
6	VENTILATING DAMPERS	2005	3,538	236	15	236		2,006	6
7	DOOR PLATES AND LOCKS	2005	3,525	176	20	176		1,496	7
8	SIGNS	2005	3,662	366	10	366		3,111	8
9	SENSOR SECURITY SYSTEM	2005	24,322	1,216	20	1,216		10,336	9
10	TELEPHONE CIRCUITRY	2005	5,483	366	15	366		3,109	10
11	FLOORING	2005	1,500	150	10	150		1,275	11
12	ALARM SYSTEM	2005	1,527	153	10	153		1,300	12
13	TELEPHONE CIRCUITRY	2005	2,163	144	15	144		1,224	13
14	WATER LINES AND BOILER	2005	33,140	1,657	20	1,657		14,085	14
15	HVAC UNIT	2005	9,280	238	39	238		1,924	15
16	HVAC UNIT	2005	7,925	793	10	793		6,738	16
17	FLOORING	2006	7,148	715	10	715		6,078	17
18	ELECTRIC PANEL	2006	1,100	55	20	55		413	18
19	FREEZER CIRCUITRY	2006	1,986	132	15	132		990	19
20	ELEVATOR HYDRAULICS RENOVATION	2006	33,276	1,664	20	1,664		12,480	20
21	DOOR LOCKS	2006	1,830	92	20	92		690	21
22	CRASH RAILS	2006	578	29	20	29		217	22
23	BIOLER PIPING	2006	1,742	87	20	87		653	23
24	SYLIGHTS	2006	3,205	160	20	160		1,200	24
25	SIDEWALKS	2006	1,400	70	20	70		525	25
26	GENRATOR ELECTRIC SYSTEM	2006	1,336	134	10	134		1,005	26
27	PARKING LOT SURFACING	2006	2,985					2,985	27
28	ELEVATOR LIGHTING	2006	1,527	76	20	76		557	28
29	WALK IN FREEAER	2006	33,813	1,691	20	1,691		12,682	29
30	SHRUBBERY	2006	4,512	338	10	338		3,100	30
31	100 WING - ELECTRICAL	2006	18,869	943	20	943		7,073	31
32	100 WING - LIGHTING	2006	4,106	205	20	205		1,537	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,904,805	\$ 105,135		\$ 118,863	\$ 13,728	\$ 3,659,036	34

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

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**

Report Period Beginning:

11/01/2012 Ending: 10/31/2013

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	
1	Totals from Page 12B, Carried Forward		\$ 4,904,805	\$ 105,135		\$ 118,863	\$ 13,728	\$ 3,659,036	1
2	100 WING - CARPETING AND DOORS	2006	6,625	331	20	331		2,482	2
3	100 WING - FLOORING	2006	4,550	228	20	228		1,710	3
4	100 WING - PLUMBING	2006	1,742	88	20	88		660	4
5	100 WING - PAINTING AND WALLPAPER	2006	8,198	410	20	410		3,075	5
6	SEWERS	2007	31,553	1,578	20	1,578		10,257	6
7	PLUMBING CONNECTIONS	2007	3,384	169	20	169		1,099	7
8	SPRINKLER SYSTEM	2007	31,188	1,650	20	1,650		10,178	8
9	KICHEN TILING	2007	1,420	142	10	142		923	9
10	THERMOSTATS	2007	3,585	358	10	358		2,327	10
11	DOORS AND LOCKS	2007	12,180	609	20	609		3,979	11
12	WINDOW TREATMENTS	2007	1,800	180	10	180		1,170	12
13	COLUMN CAPS	2007	7,534	462	20	462		2,833	13
14	ROOFING	2007	1,050	53	20	53		343	14
15	AUTOMATIC DOORS	2007	2,972	149	20	149		968	15
16	ELECTRICAL PANEL	2007	9,128	456	20	456		2,964	16
17	HAND RAILS	2007	3,200	160	20	160		1,040	17
18	100 WING - LIGHTING	2007	5,450	272	20	272		1,768	18
19	100 WING - DOORS	2007	3,885	194	20	194		1,261	19
20	100 WING - PAINTING AND WALLPAPER	2007	1,596	80	20	80		520	20
21	FIRE ALARM SYSTEM	2008	15,772	789	20	789		4,339	21
22	AIR CONDITIONING UNIT	2008	1,700	170	10	170		935	22
23	WATER LINE	2008	14,210	474	30	474		2,607	23
24	CIRCUIT BREAKERS	2008	1,140	57	20	57		313	24
25	HEAT PUMB	2008	6,525	653	101	653		3,591	25
26	KITCHEN TILING	2008	1,018	51	20	51		280	26
27	SPRINKLER SYSTEM	2008	3,986	199	20	199		1,095	27
28	STORAGE ROOM DOORS	2008	12,170	609	20	609		3,349	28
29	CARPETING	2008	2,825	283	10	283		1,556	29
30	CARPETING	2008	2,580	258	10	258		1,419	30
31	WALL PANELS	2008	3,267	163	20	163		897	31
32	MAINTENANCE SINK	2008	965	48	20	48		264	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,112,003	\$ 116,458		\$ 130,186	\$ 13,728	\$ 3,729,238	34

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

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**

Report Period Beginning:

11/01/2012 Ending: 10/31/2013

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	
1	Totals from Page 12C, Carried Forward		\$ 5,112,003	\$ 116,458		\$ 130,186	\$ 13,728	\$ 3,729,238	1
2	SPRINKLER SYSTEM	2008	1,155	30	39	30		178	2
3	STORAGE ROOM DOORS	2008	3,958	101	39	101		604	3
4	DOOR LOCKS	2008	3,358	168	20	168		924	4
5	BOILER AND WATER TANKS	2008	11,920	596	20	596		3,276	5
6	RETAINING WALL	2008	46,418	2,321	20	2,321		12,765	6
7	DOORS AND LOCKS	2008	1,939	97	20	97		533	7
8	DRYER EXHAUST FANS	2008	4,313	431	10	431		2,371	8
9	CARPETING	2008	3,600	360	10	360		1,980	9
10	LANDSCAPING AND SHRUBBERY	2008	18,783	939	20	939		5,165	10
11	ELECATOR - ELECTRICAL	2009	58,435	1,498	39	1,498		6,742	11
12	WATER LINE PIPING	2009	15,146	388	39	388		1,746	12
13	FIRE ALARM SYSTM	2009	15,302	392	39	392		1,797	13
14	SKYLIGHTS	2009	9,175	458	20	458		2,061	14
15	FLOORING	2009	2,092	209	10	209		941	15
16	FIRE ALARM SYSTM	2009	5,273	135	39	135		608	16
17	NURSE CALL STATION	2009	5,186	132	39	132		594	17
18	TELEPHONE LINES	2009	3,810	381	10	381		1,715	18
19	LABBY AND HALLWAY CARPETING	2009	37,322	2,488	15	2,488		11,188	19
20		2009	10,884	726	15	726		3,264	20
21	LABBY WINDOW TREATMENTS AND DOORS	2009	19,249	1,283	15	1,283		5,770	21
22	LABBY HALLWAY WALL REFINISHING	2009	23,229	1,549	15	1,549		6,965	22
23	FIRE ALARM SYSTM	2009	758	19	39	19		86	23
24	DRIVEWAY TO ROUTE 1736	2009	119,776	3,071	39	3,071		13,820	24
25	PARKING LOT REPAVING	2009	8,499	567	15	567		2,551	25
26	PARKNG LOST STIPING	2009	4,495	300	15	300		1,350	26
27	A/C COMPRESSOR	2009	3,348	334	10	334		1,503	27
28	PUMBING AND HOT WATER TANK	2009	5,532	142	39	142		638	28
29	SUMP DRAIN	2010	1,200	60	20	60		210	29
30	FLOORING - BEAUTY SHOP	2010	4,182	418	10	418		1,463	30
31	FIXTURES - BEAUTY SHOP	2010	3,025	148	10	148		518	31
32	FIRE SYSEM FAN	2010	13,477	346	39	346		1,211	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,576,842	\$ 136,545		\$ 150,273	\$ 13,728	\$ 3,823,775	34

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

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**

Report Period Beginning:

11/01/2012 Ending: 10/31/2013

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	
1	Totals from Page 12D, Carried Forward		\$ 5,576,842	\$ 136,545		\$ 150,273	\$ 13,728	\$ 3,823,775	1
2	SAFETY UNITS	2010	1,400	140	10	140		490	2
3	WATER MAIN	2010	19,875	510	39	510		1,785	3
4	LOBBY FLOORING	2010	1,737	174	10	174		609	4
5	STORM DRAIN	2010	4,072	104	39	104		364	5
6	KITCHEN TILING	2010	25,291	1,686	15	1,686		5,901	6
7	FLOORING - DINING ROOM	2010	30,348	3,034	10	3,034		10,619	7
8	WOMENS' BATHROOM	2010	2,134	214	10	214		749	8
9	ROOFING A/C UNIT	2010	4,120	412	10	412		1,442	9
10	FLOORING - EAST ACTIVITY ROOM	2010	22,731	2,274	10	2,274		7,959	10
11	KITHCEN CABINetry	2010	754	76	10	76		266	11
12	TEEPHONE CABLING	2010	875	44	20	44		154	12
13	LANDSCAPING	2010	1,940	98	20	98		343	13
14	PARKING LOT SEWERS ND DRAINS	2011	9,020	452	20	452		1,130	14
15	PARKING LOT PAVING	2011	10,308	516	20	516		1,290	15
16	LANDSCAPING	2011	3,141	156	20	156		390	16
17	CONCRETE CURBS	2011	9,526	476	20	476		1,190	17
18	PARKING LOT PAVING AND RESURFACING	2011	43,555	1,452	30	1,452		3,630	18
19	PARKING LOT EXCAVATION	2011	137,968	4,598	30	4,598		11,496	19
20	SHRUBBERY AND LANDSCAPING	2011	38,289	1,914	20	1,914		4,785	20
21	FENCING	2011	9,069	454	20	454		1,135	21
22	WALL RESTORATION	2011	3,000	200	15	200		350	22
23	KITCHEN TILING	2011	2,100	210	10	210		525	23
24	SRU TELEPHONE LINE	2011	59,780	3,959	15	3,959		9,938	24
25	CORE ROOFING	2011	83,325	4,166	20	4,166		10,415	25
26	WIFI	2011	4,241	212	20	212		530	26
27	FIRE CONTROLS	2011	9,488	474	20	474		1,185	27
28	FLOOGIN AND BORDERS	2011	5,060	506	10	506		1,265	28
29	WALL LAMPS	2011	5,630	376	15	376		940	29
30	FLOORING AND TRIM	2011	13,575	1,358	10	1,358		3,395	30
31	RAILS AND MOLDINGS	2011	12,150	608	20	608		1,520	31
32	ROOFING A/C UNIT	2011	2,455	246	10	246		615	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,153,799	\$ 167,644		\$ 181,372	\$ 13,728	\$ 3,910,180	34

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

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**

Report Period Beginning:

11/01/2012 Ending: 10/31/2013

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	
1	Totals from Page 12E, Carried Forward		\$ 6,153,799	\$ 167,644		\$ 181,372	\$ 13,728	\$ 3,910,180	1
2	HALLWAY CARPETING	2011	44,500	2,967	15	2,967		6,665	2
3	FREEZER RAMP	2011	4,143	208	20	208		520	3
4	CARPETING - 300 HALL	2011	28,451	730	39	730		1,276	4
5	ALARM SYSTEM	2011	3,103	207	15	207		267	5
6	SPINKLERS	2011	6,787	174	39	174		435	6
7	SOLO TUBING	2011	2,013	202	10	202		505	7
8	WINDOW TREATMENTS	2011	1,371	138	10	138		345	8
9	FLOORING - 400 HALL	2011	13,575	679	20	679		2,715	9
10	LOBBY ABATEMENT	2011	57,381	2,869	20	2,869		8,019	10
11	WALL RECONSTRUCTION	2012	6,300	315	20	315		473	11
12	DOOR LOCKS	2012	2,039	102	20	102		153	12
13	FLOORING - LINEN ROOM	2012	1,025	51	20	51		77	13
14	PTAC UNITS	2012	23,805	1,587	15	1,587		2,381	14
15	WINDOW TREATMENTS	2012	5,084	508	10	508		762	15
16	FLOORING - THERAPY ROOM	2012	10,280	514	20	514		770	16
17	ROOF A/C UNIT	2012	3,220	215	15	215		322	17
18	CHAIR RAILS	2012	1,310	66	20	66		99	18
19	ELEVATOR SENSORS	2012	1,538	77	20	77		115	19
20	OUTER DOORS	2012	10,788	540	20	540		810	20
21	FLOORING - 400 HALL	2012	13,750	688	20	688		1,032	21
22	WINDOW TREATMENTS AND RENOVATION	2012	11,652	816	20	816		1,224	22
23	CARRIER UNIT	2012	3,941	263	15	263		394	23
24	DOORS - FIRE RATED	2013	1,590	20	39	20		20	24
25	CABINETS - MED ROOM	2013	4,800	120	20	120		120	25
26	LOBBY AND HALLWAY PAINTING AND WALLPAPER	2013	11,206	560	10	560		560	26
27	A/C UNITS - ROOF	2013	42,615	1,065	20	1,065		1,065	27
28	ROOF SOFITING	2013	46,950	1,174	20	1,174		1,174	28
29	SECURITY SYSTEM	2013	34,950	874	20	874		874	29
30	SPRINKLER SYSTEM EXTENSION	2013	7,985	200	20	200		200	30
31	PARKING LOT SURFACING	2013	5,523	276	20	276		276	31
32	LANDSCAPING	2013	1,415	24	30	24		24	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,566,889	\$ 185,873		\$ 199,601	\$ 13,728	\$ 3,943,852	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	\$ 685,890	\$ 62,582	\$ 62,582	\$	5yr - 15yr	\$ 375,122	71
72	Current Year Purchases	87,866	3,527	3,527		5yr - 15yr	3,527	72
73	Fully Depreciated Assets	1,575,359	7,569	7,569		5yr - 15yr	1,575,359	73
74								74
75	TOTALS	\$ 2,349,115	\$ 73,678	\$ 73,678	\$		\$ 1,954,008	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	BUSINESS	2010 FORD VAN	2010	\$ 23,846	\$ 2,385	\$ 2,385	\$	10 yr	\$ 8,346	76
77										77
78										78
79										79
80	TOTALS			\$ 23,846	\$ 2,385	\$ 2,385	\$		\$ 8,346	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)	\$ 9,040,613	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 261,936	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 275,664	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,728	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,906,206	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ N/A			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 NONE.

9. Option to Buy: YES NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2014</u>	\$ _____
13.	<u>/2015</u>	\$ _____
14.	<u>/2016</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	\$	\$ NONE	\$ NONE	\$ NONE
10	SUM OF line 9, col. 1 and 2 (e)	\$ NONE			

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	NONE

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	626,000	\$ 695,510	\$	626,000	\$ 695,510	1
2	Licensed Speech and Language Development Therapist		hrs		88,000	98,139		88,000	98,139	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		676,000	750,497		676,000	750,497	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	1,390,000	\$ 1,544,146	\$	1,390,000	\$ 1,544,146	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **10/31/2013**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 186,520	\$ 423,956	1
2	Cash-Patient Deposits	5,646	5,646	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u>)	2,217,399	2,268,448	3
4	Supply Inventory (priced at <u>cost</u>)	281,405	341,807	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,101	17,101	6
7	Other Prepaid Expenses	105,201	139,910	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,813,272	\$ 3,196,868	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		2,109,879	12
13	Land	100,763	236,453	13
14	Buildings, at Historical Cost	6,566,889	13,588,957	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,372,961	3,254,822	16
17	Accumulated Depreciation (book methods)	(5,906,206)	(8,679,442)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	256,070	660,510	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(122,913)	(311,229)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Progress</u>		49,531	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,267,564	\$ 10,909,481	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,080,836	\$ 14,106,349	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 714,850	\$ 708,268	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	250,000	250,000	29
30	Accrued Salaries Payable	346,881	390,623	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,242	18,613	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Resident and Other Credit Balances</u>	43,896	249,171	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,361,869	\$ 1,616,675	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,983,293	6,255,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,983,293	\$ 6,255,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,345,162	\$ 7,871,675	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,735,674	\$ 6,234,674	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,080,836	\$ 14,106,349	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,090,950	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,090,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	143,724	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)	\$ 143,724	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)	\$ 6,234,674	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,134,161	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,134,161	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,156,284	6
7	Oxygen	78,140	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,234,424	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	10,609	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)	\$ 10,609	23
D. Non-Operating Revenue			
24	Contributions	6,264	24
25	Interest and Other Investment Income****	63,853	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 70,117	26
E. Other Revenue (specify):*****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Realized Gain on Invesatments</u>	121,423	28
28a	<u>Unrealized Gain on Investments</u>	72,134	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 193,557	29

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,753,993	31
32	Health Care	7,661,215	32
33	General Administration	3,076,168	33
B. Capital Expense			
34	Ownership	805,231	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee and Bed Tax	202,537	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,499,144	40
41	Income before Income Taxes (line 30 minus line 40)**	143,724	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 143,724	43

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

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	14,642,868	30
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***Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ROLLING HILLS MANOR**

0025239

Report Period Beginning: **11/01/2012**

Ending: **10/31/2013**

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	1,960	2,200	\$ 77,043	\$ 35.02	1
2	Assistant Director of Nursing	1,816	1,920	69,223	36.05	2
3	Registered Nurses	33,919	37,728	1,280,326	33.94	3
4	Licensed Practical Nurses	25,187	27,766	768,294	27.67	4
5	CNAs & Orderlies	129,995	142,052	1,766,798	12.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,904	6,417	90,805	14.15	8
9	Activity Director	1,920	2,200	51,900	23.59	9
10	Activity Assistants	6,247	6,802	72,923	10.72	10
11	Social Service Workers	3,944	4,264	105,557	24.76	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,200	60,424	27.47	13
14	Head Cook	6,603	7,306	134,992	18.48	14
15	Cook Helpers/Assistants	18,386	20,193	177,511	8.79	15
16	Dishwashers					16
17	Maintenance Workers	19,114	21,136	225,140	10.65	17
18	Housekeepers	25,733	28,508	283,937	9.96	18
19	Laundry	17,157	19,270	195,444	10.14	19
20	Administrator	1,976	2,080	106,735	51.31	20
21	Assistant Administrator					21
22	Other Administrative	7,437	8,037	91,716	11.41	22
23	Office Manager	1,960	2,200	73,253	33.30	23
24	Clerical	9,035	9,873	195,935	19.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,024	2,080	64,938	31.22	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,476	2,607	39,717	15.23	31
32	Health Care MDS Coordinator	2,000	2,200	74,932	34.06	32
33	Other Executive Director	1,872	2,080	111,858	53.78	33
34	TOTAL (lines 1 - 33)	328,681	361,119	\$ 6,119,401 *	\$ 16.95	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	1,602	\$ 40,043	1:3	35
36	Medical Director	200	15,000	9:3	36
37	Medical Records Consultant	78	1,568	10:3	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	57	2,023	12:3	44
45	Social Service Consultant	32	1,598	10:3	45
46	Other (specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,969	\$ 60,232		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)		\$ NONE		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		
Miron Tabic	Administrator	None	\$ 106,735	Workers' Compensation Insurance	\$ 124,284	IDPH License Fee	\$ 3,980		
James S. Stefo, Sr.	Executive Director	None	111,858	Unemployment Compensation Insurance	4,107	Advertising: Employee Recruitment	4,061		
				FICA Taxes	459,288	Health Care Worker Background Check (Indicate # of checks performed 260)	11,719		
				Employee Health Insurance	448,210				
				Employee Meals	26,268	Advertising and Promotion	24,729		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council for Long Term Care	12,813		
				PTO Expense	21,009	Memberships	2,294		
				Employee Retirement Funding	55,081				
				Employee Meal Reimbursement	(10,609)				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 218,593	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,127,638	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 40,230
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Bad Debt Expense			\$ 57,192				Out-of-State Travel	\$	
							In-State Travel		
							Automobile Expense	739	
							Travel reimbursements	1,777	
							Seminar Expense	7,748	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 57,192	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 10,264
C. Professional Services									
Vendor/Payee	Type		Amount						
Frrost and Ruttenburg	General Audit		\$ 23,066						
Frrost and Ruttenburg	401K Audit		6,000						
James S. Stefo and Co.	Accounting		7,020						
Posinelli and Shughart	Legal		30,973						
Smioth Amundsen	Legal: Total bills attached		4,933						
Less: Smith Amundsen	Legal: Rolling Hills Place		(1,277)						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 70,715						

* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ NONE		\$	\$	\$	\$	\$	\$	\$	\$								

Facility Name & ID Number ROLLING HILLS MANOR# 0025239Report Period Beginning: 11/01/2012Ending: 10/31/2013**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. ICLLC \$12,813
- (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? N/A
- (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? 5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 64,251 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. \$ 62,963
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. \$ YES Has any meal income been offset against related costs? 26,268 Indicate the amount. \$ 10,609
- (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? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
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. \$ NONE
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FROST AND RUTTENBURG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

