		FOR BHF USE				

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0052589

Facility Name: Elmhurst Extended Care Ctr

Address: 200 East Lake Street (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: (630) 516-5000 **Fax #** (630) 834-0480

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2014

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 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) Andrew B. Cutler, Managing Director

(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015

(Telephone) (847) 940-3269 Fax # (847) 940-3269

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler Telephone Number: (847) 940-3269
Email Address:

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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	765	3,418	5,112	9,295	8
9	SNF/PED					9
10	ICF	2,429	15,627		18,056	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,194	19,045	5,112	27,351	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.38%

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 [ ]

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

I. On what date did you start providing long term care at this location?
Date started 12/31/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 39 and days of care provided 5,112

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	258,322	39,885		298,207		298,207	(11,229)	286,978			1
2	Food Purchase		187,591		187,591		187,591		187,591			2
3	Housekeeping	152,817	31,878		184,695		184,695		184,695			3
4	Laundry	31,875	8,351		40,226		40,226		40,226			4
5	Heat and Other Utilities			122,731	122,731		122,731		122,731			5
6	Maintenance	71,522		106,313	177,835		177,835		177,835			6
7	Other (specify):*											7
8	**TOTAL General Services**	514,536	267,705	229,044	1,011,285		1,011,285	(11,229)	1,000,056			8
	B. Health Care and Programs											
9	Medical Director			58,755	58,755		58,755		58,755			9
10	Nursing and Medical Records	2,132,437	262,136	76,378	2,470,951		2,470,951	(34,425)	2,436,526			10
10a	Therapy		6,710	3,332	10,042		10,042		10,042			10a
11	Activities	118,879	71	1,945	120,895		120,895		120,895			11
12	Social Services	67,454			67,454		67,454		67,454			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,318,770	268,917	140,410	2,728,097		2,728,097	(34,425)	2,693,672			16
	C. General Administration											
17	Administrative	95,511			95,511		95,511		95,511			17
18	Directors Fees											18
19	Professional Services			26,318	26,318		26,318	(4,819)	21,499			19
20	Dues, Fees, Subscriptions & Promotions			41,446	41,446		41,446	(30,808)	10,638			20
21	Clerical & General Office Expenses	298,215	6,867	126,030	431,112		431,112	(100,600)	330,512			21
22	Employee Benefits & Payroll Taxes			466,108	466,108		466,108		466,108			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,462	10,462		10,462		10,462			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			97,865	97,865		97,865		97,865			26
27	Other (specify):*											27
28	**TOTAL General Administration**	393,726	6,867	768,229	1,168,822		1,168,822	(136,227)	1,032,595			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,227,032	543,489	1,137,683	4,908,204		4,908,204	(181,881)	4,726,323			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	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			2,743	2,743		2,743	1,101,879	1,104,622			30
31	Amortization of Pre-Op. & Org.							21,660	21,660			31
32	Interest			57,840	57,840		57,840	306,910	364,750			32
33	Real Estate Taxes			51,033	51,033		51,033	(52,261)	(1,228)			33
34	Rent-Facility & Grounds			388,060	388,060		388,060	(385,967)	2,093			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			499,676	499,676		499,676	992,221	1,491,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	313,356	264,371	73,022	650,749		650,749		650,749			39
40	Barber and Beauty Shops			11,936	11,936		11,936	(11,936)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,970	193,970		193,970		193,970			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	313,356	264,371	278,928	856,655		856,655	(11,936)	844,719			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,540,388	807,860	1,916,287	6,264,535		6,264,535	798,404	7,062,939			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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Reference	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				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	23,367	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,974)	21		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	(4,100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,937)	21		24
25	Fund Raising, Advertising and Promotional	(9,880)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(20,928)	20		28
29	Other-Attach Schedule	(110,998)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (170,450)		$	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)	968,854		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 968,854		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 798,404		37

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

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

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

Elmhurst Extended Care Ctr

ID# 0052589

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Expense	$ (11,229)	01	1
2	Misc Income	(91)	21	2
3	Barber & Beauty	(11,936)	40	3
4	Bank Charges	(402)	21	4
5	Non-Allowable Legal	(4,819)	19	5
6	Rebates	(436)	21	6
7	Other Income	(5,000)	21	7
8	Marketing Salaries	(42,660)	21	8
9	Dialysis Income offset	(34,425)	10	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**	(110,998)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	(11,229)	0	0	0	0	0	0	0	0	0	0	(11,229)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,229)	0	0	0	0	0	0	0	0	0	0	(11,229)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(34,425)	0	0	0	0	0	0	0	0	0	0	(34,425)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(34,425)	0	0	0	0	0	0	0	0	0	0	(34,425)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,819)	0	0	0	0	0	0	0	0	0	0	(4,819)	19
20	Fees, Subscriptions & Promotions	(30,808)	0	0	0	0	0	0	0	0	0	0	(30,808)	20
21	Clerical & General Office Expenses	(100,600)	0	0	0	0	0	0	0	0	0	0	(100,600)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(136,227)	0	0	0	0	0	0	0	0	0	0	(136,227)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(181,881)	0	0	0	0	0	0	0	0	0	0	(181,881)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	23,367	1,078,512	0	0	0	0	0	0	0	0	0	1,101,879	30
31	Amortization of Pre-Op. & Org.	0	21,660	0	0	0	0	0	0	0	0	0	21,660	31
32	Interest	0	306,910	0	0	0	0	0	0	0	0	0	306,910	32
33	Real Estate Taxes	0	(52,261)	0	0	0	0	0	0	0	0	0	(52,261)	33
34	Rent-Facility & Grounds	0	(385,967)	0	0	0	0	0	0	0	0	0	(385,967)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	23,367	968,854	0	0	0	0	0	0	0	0	0	992,221	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(11,936)	0	0	0	0	0	0	0	0	0	0	(11,936)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(11,936)	0	0	0	0	0	0	0	0	0	0	(11,936)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(170,450)	968,854	0	0	0	0	0	0	0	0	0	798,404	45

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
Love Dave	15					
Madhusudan Dave	60					
Dipti Dave	25					

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	34	Rent	$ 385,967	LKNY, LLC		$	$ (385,967)	1
2	V	30	Depreciation Expense		LKNY, LLC		1,078,512	1,078,512	2
3	V	31	Amortization Expense		LKNY, LLC		21,660	21,660	3
4	V	32	Mortgage Interest		LKNY, LLC		284,736	284,736	4
5	V	33	Real Estate Taxes	51,033	LKNY, LLC		(1,228)	(52,261)	5
6	V	32	Interest Expense - LOC		LKNY, LLC		22,174	22,174	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 437,000			$ 1,405,854	$ * 968,854	14

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

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

Facility Name & ID Number: Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Love Dave	Owner	Administrator	15.00	None	40	100.00	Salary	$ 73,941	17-01	1
2	Madhusdan Dave	Owner	Administrative	60.00	None	40	100.00	Salary	42,980	21-01	2
3	Dipti Dave	Owner	Bookkeeping	25.00	None	40	100.00	Salary	70,768	21-01	3
4	Love Dave	Owner	Marketing (Adj,P5	15.00	None	40	100.00	Salary	17,036	21-01	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 204,725		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: Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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**		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	Ridgestone Bank		X	Mortgage			$ 5,000,000	$ 3,813,393		Prime+2.5	$ 284,736	1
2	Seller Finance		X	Seller Finance			1,000,000	977,221			57,840	2
3												3
4												4
5												5
	Working Capital											
6	Ridgestone Bank		X	Working Capital - LOC			500,000	285,000		Prime+3%	22,203	6
7												7
8												8
9	TOTAL Facility Related						$ 6,500,000	$ 5,075,614			$ 364,779	9
	B. Non-Facility Related*											
10	LKNY	X		Interest Income							(29)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (29)	14
15	TOTALS (line 9+line14)						$ 6,500,000	$ 5,075,614			$ 364,750	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: Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2013 report.	$		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.)	$	49,805	2
3. Under or (over) accrual (line 2 minus line 1).	$	49,805	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	49,805	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2009		8
2010		9
2011		10
2012		11
2013	51,033	12

FOR BHF USE ONLY

Line	Item		Line
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

No R/E Tax accrual as R/E Taxes are paid by Building Partnership and reclassified as part of Rent.

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.**

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmhurst Extended Care Ctr COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0052589

CONTACT PERSON REGARDING THIS REPORT Andrew Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	03-36-309-029	Long-Term Care Property	$ 51,033.10	$ 51,033.10
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,033.10	$ 51,033.10

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 X________ 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,019 B. General Construction Type: Exterior Brick Frame Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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).

None

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

1. Total Amount Incurred: 222,344 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 21,666 4. Dates Incurred:

Nature of Costs: Loan Fees
(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	41,851	2013	$ 92,016	1
2	Parking Lot			6,950	2
3	TOTALS	41,851		$ 98,966	3

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	108		2013		$ 2,860,030	$ 90,727	27	$ 115,311	$ 24,584	$ 115,311	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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	Book Depreciation					2,743					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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Elevator- Motor and Starter Replacement	2014	$ 5,545	$	20	$ 277	$ 277	$ 277	37
38	Parking Lot Pavement Repair	2014	4,166		20	208	208	208	38
39	Fire Alarm Repair	2014	3,916		20	196	196	196	39
40	Fire Panel/Damper	2014	64,700		20	539	539	539	40
41	Exhaust Fan	2014	6,111		20	306	306	306	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,944,468	$ 93,470		$ 116,837	$ 26,110	$ 116,837	70

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,944,468	$ 93,470		$ 116,837	$ 23,367	$ 116,837	1
2	Building Company:								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	TOTAL (lines 1 thru 33)		$ 2,944,468	$ 93,470		$ 116,837	$ 23,367	$ 116,837	34

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 2,498,125	$ 495,972	$ 495,972	$	5	$ 495,972	71
72	Current Year Purchases	39,222	2,075	2,075		5	2,075	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,537,347	$ 498,047	$ 498,047	$		$ 498,047	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,580,781	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 591,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 614,884	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 23,367	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 614,884	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?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Office Storage Rental				2,093			5
6								6
7	TOTAL				$ 2,093 **			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 [X] 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.	/2015	$
13.	/2016	$
14.	/2017	$

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

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	39-01, 39-03	hrs	$ 117,273		$ 14,795	$		$ 132,068	1
2	Licensed Speech and Language Development Therapist	39-01, 39-03	hrs			12,480			12,480	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01, 39-03	hrs	196,083		30,550			226,633	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				264,371		264,371	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-Ray						15,197		15,197	12
13	Other (specify):									13
14	TOTAL			$ 313,356		$ 57,825	$ 279,568		$ 650,749	14

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 804,761	$ 839,923	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	500,157	500,157	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	842	842	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,000	3,000	8
9	Other(specify): See Attached	1,955	1,955	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,310,715	$ 1,345,877	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		476,852	13
14	Buildings, at Historical Cost		2,486,821	14
15	Leasehold Improvements, at Historical Cost	70,811	444,020	15
16	Equipment, at Historical Cost	40,846	2,606,434	16
17	Accumulated Depreciation (book methods)	(2,743)	(1,177,077)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,660)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		179,465	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 108,914	$ 4,994,855	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,419,629	$ 6,340,732	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 100,007	$ 100,007	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,694	333,694	30
31	Accrued Taxes Payable (excluding real estate taxes)	296	296	31
32	Accrued Real Estate Taxes(Sch.IX-B)		5,659	32
33	Accrued Interest Payable	10,411	10,411	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	42,702	42,702	35
	Other Current Liabilities(specify):			
36	See Attached		30,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 487,110	$ 522,769	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	977,221	1,487,221	39
40	Mortgage Payable		4,908,393	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)**	$ 977,221	$ 6,395,614	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,464,331	$ 6,918,383	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (44,702)	$ (577,651)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,419,629	$ 6,340,732	48

*(See instructions.)

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A. Current Assets	**Operating**	**After Consolidation**
9 Due from Employees	1,955.00	1,955.00
	1,955.00	1,955.00

B. Long-Term Assets	Amount	
23 Loan Fees	0	179,465.00
	-	179,465.00

Other Current Liabilities	Amount	
36 Due to Related Parties	0	30,000.00
	-	30,000.00

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):	(997,000)	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (997,000)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	952,298	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)**	$ 952,298	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)**	$ (44,702)	24 *

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

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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	$ 9,438,516	1
2	Discounts and Allowances for all Levels	(3,969,753)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,468,763	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	972,611	6
7	Oxygen	38,398	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,011,009	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	17,263	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	236,323	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,886	19
20	Radiology and X-Ray	6,693	20
21	Other Medical Services	369,301	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 638,466	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	611	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 611	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Misc. Income/Vending Income/Loss on FI	97,984	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 97,984	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,216,833	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,011,285	31
32	Health Care	2,728,097	32
33	General Administration	1,168,822	33
	B. Capital Expense		
34	Ownership	499,676	34
	C. Ancillary Expense		
35	Special Cost Centers	662,685	35
36	Provider Participation Fee	193,970	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,264,535	40
41	**Income before Income Taxes (line 30 minus line 40)****	952,298	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 952,298	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 389,876	44
45	Private Pay - Net Inpatient Revenue	3,892,794	45
46	Medicare - Net Inpatient Revenue	1,050,293	46
47	Other-(specify) Hospice	45,091	47
48	Other-(specify) Insurance/Managed Care	90,709	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,468,763	49

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

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

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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	2,055	2,231	$ 80,813	$ 36.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,960	16,839	592,023	35.16	3
4	Licensed Practical Nurses	16,195	17,602	479,761	27.26	4
5	CNAs & Orderlies	67,088	72,048	919,564	12.76	5
6	CNA Trainees					6
7	Licensed Therapist	7,414	7,807	316,969	40.60	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,120	59,236	27.94	9
10	Activity Assistants	4,086	4,328	59,643	13.78	10
11	Social Service Workers	1,912	2,128	67,454	31.70	11
12	Dietician	2,059	2,315	60,852	26.29	12
13	Food Service Supervisor					13
14	Head Cook	1,981	2,221	42,876	19.30	14
15	Cook Helpers/Assistants	4,217	4,721	69,359	14.69	15
16	Dishwashers	8,392	8,782	85,235	9.71	16
17	Maintenance Workers	2,227	2,555	71,522	27.99	17
18	Housekeepers	11,359	12,615	152,817	12.11	18
19	Laundry	2,652	2,884	31,875	11.05	19
20	Administrator	2,064	2,160	95,511	44.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	384	400	13,451	33.63	23
24	Clerical	9,112	9,841	284,764	28.94	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	1,880	1,928	14,556	7.55	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,941	175,525	$ 3,498,281 *	$ 19.93	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	50,305	09-03	36
37	Medical Records Consultant	39	2,310	10-03	37
38	Nurse Consultant	Monthly	48,254	10-03	38
39	Pharmacist Consultant	Monthly	3,340	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	880	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	55	$ 105,089		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	408	$ 14,360	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	636	8,114	10-03	52
53	TOTAL (lines 50 - 52)	1,044	$ 22,474		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Love Dave 3/1/2014-Present	Administrator	15	$ 73,941
John Massard 1/1/2014- 2/2/2014	Administrator	0	21,570
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,511

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Polsinelli	Legal	$ 2,760
Keith Goldberg	Legal	4,818
Talx	Unemployment Consulting	1,266
ARS	401(k)	3,800
FGMK, LLC	Accounting	12,074
Michigan Peer Review	Legal	1,600
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 26,318

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,914
Unemployment Compensation Insurance	41,927
FICA Taxes	264,297
Employee Health Insurance	66,170
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Matching	14,920
Employee Physicals	880
TOTAL (agree to Schedule V, line 22, col.8)	$ 466,108

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 2,089
Advertising: Employee Recruitment		
Health Care Worker Background Check		
(Indicate # of checks performed	16)	737
Patient Background Checks	110	1,151
Dues and Subscriptions		6,661
Public Relations		9,880
Yellow Page Advertising		20,928
Less: Public Relations Expense		( )
Non-allowable advertising		(9,880)
Yellow page advertising		(20,928)
TOTAL (agree to Sch. V, line 20, col. 8)		$ 10,638

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,477
Seminar Expense	8,985
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,462

**See instructions.

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Legal Schedule
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Date	Vendor	Amount	ADJ	Allowable
1/3/2014	Polsinelli	2,050.80		2,050.80
1/30/2014	Polsinelli	708.92		708.92
1/30/2014	Keith Goldberg	185.00	(185.00)	-
1/30/2014	Keith Goldberg	185.00	(185.00)	-
2/28/2014	Keith Goldberg	185.00	(185.00)	-
3/31/2014	Keith Goldberg	635.00	(635.00)	-
4/30/2014	Keith Goldberg	585.00	(585.00)	-
5/31/2014	Keith Goldberg	972.50	(972.50)	-
7/31/2014	Keith Goldberg	1,533.76	(1,533.76)	-
8/31/2014	Keith Goldberg	413.75	(413.75)	-
9/30/20144	Keith Goldberg	635.00	(635.00)	-
10/31/2014	Keith Goldberg	518.25	(518.25)	-
11/30/2014	Keith Goldberg	1,187.05	(1,187.05)	-
9/19/2014	Michigan Peer Review	1,600.00		1,600.00
12/31/2014	Legal Fees Billed	(2,216.78)	2,216.78	-
		$9,178.25	$(4,818.53)	$ 4,359.72

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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. **IHCA - $5,664**

(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. $ **26,453** 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. $ **193,970**
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. $ **0** 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. N/A
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? **Yes**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.