

Facility Name & ID Number ROLLING HILLS MANOR

0025239 Report Period Beginning: 11/01/2005 Ending: 10/31/2006

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 4/29/2005

	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	<u>127</u>	Skilled (SNF)	<u>127</u>	<u>46,355</u>	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	<u>127</u>	TOTALS	<u>127</u>	<u>46,355</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>19,768</u>	<u>14,524</u>	<u>8,968</u>	<u>43,260</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,768</u>	<u>14,524</u>	<u>8,968</u>	<u>43,260</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.32%

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 127 and days of care provided 8,968

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/2006 Fiscal Year: 10/31/2006

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

Facility Name & ID Number **ROLLING HILLS MANOR** # **0025239** Report Period Beginning: **11/01/2005** Ending: **10/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	298,096	26,275	33,640	358,011		358,011		358,011		1
2	Food Purchase		183,604		183,604	(6,318)	177,286	(1,692)	175,594		2
3	Housekeeping	303,452	25,866		329,318		329,318		329,318		3
4	Laundry	126,776	31,918	6,970	165,664		165,664		165,664		4
5	Heat and Other Utilities			147,573	147,573		147,573		147,573		5
6	Maintenance	103,449	14,191	50,469	168,109		168,109	(18,852)	149,257		6
7	Other (specify):* Rolling Hills Place			761,264	761,264		761,264	(761,264)			7
8	TOTAL General Services	831,773	281,854	999,916	2,113,543	(6,318)	2,107,225	(781,808)	1,325,417		8
	B. Health Care and Programs										
9	Medical Director			8,650	8,650		8,650		8,650		9
10	Nursing and Medical Records	2,916,593	203,038	455,541	3,575,172	(350,417)	3,224,755		3,224,755		10
10a	Therapy			654,628	654,628		654,628		654,628		10a
11	Activities	100,084	3,775	7,440	111,299		111,299		111,299		11
12	Social Services	67,994	1,088		69,082		69,082		69,082		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Rolling Hills Place			361,318	361,318		361,318	(361,318)			15
16	TOTAL Health Care and Programs	3,084,671	207,901	1,487,577	4,780,149	(350,417)	4,429,732	(361,318)	4,068,414		16
	C. General Administration										
17	Administrative	161,717		221,808	383,525		383,525	(221,808)	161,717		17
18	Directors Fees			12,536	12,536		12,536		12,536		18
19	Professional Services			69,703	67,203		67,203		67,203		19
20	Dues, Fees, Subscriptions & Promotions			37,501	37,501		37,501	(19,562)	17,939		20
21	Clerical & General Office Expenses	351,120	49,417	154,206	549,743		549,743	(36,072)	513,671		21
22	Employee Benefits & Payroll Taxes			827,068	834,568	6,318	840,886	(6,318)	834,568		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,042	11,042		11,042		11,042		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			80,950	80,950		80,950	22,695	103,645		26
27	Other (specify):* Rolling Hills Place			512,197	512,197		512,197	(512,197)			27
28	TOTAL General Administration	512,837	49,417	1,927,011	2,489,265	6,318	2,495,583	(773,262)	1,722,321		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,429,281	539,172	4,414,504	9,382,957	(350,417)	9,032,540	(1,916,388)	7,116,152		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 OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			195,459	195,459		195,459	6,847	202,306			30
31	Amortization of Pre-Op. & Org.											31
32	Interest and Bond Costs			116,373	116,373		116,373	(116,373)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Rolling hills Pl.			467,208	467,208		467,208	(467,208)				36
37	TOTAL Ownership			779,040	779,040		779,040	(576,734)	202,306			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			6,116	6,116		6,116		6,116			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,534	69,534		69,534		69,534			42
43	Other (specify):* Prescription Drugs					350,417	350,417		350,417			43
44	TOTAL Special Cost Centers			75,650	75,650	350,417	426,067		426,067			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,429,281	539,172	5,269,194	10,237,647		10,237,647	(2,493,122)	7,744,525			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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,318)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(18,852)	6		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,847	30		9
10	Interest and Other Investment Income	(116,373)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,692)	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	(221,808)	17		24
25	Fund Raising, Advertising and Promotional	(19,562)	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)	\$ (377,758)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule -2115364	(2,115,364)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,115,364)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,493,122)		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		350,417	43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 350,417	47

BHF USE ONLY					
48	49	50	51	52	

ROLLING HILLS MANOR

ID# 0025239

Report Period Beginning: 11/01/2005

Ending: 10/31/2006

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:

11/01/2005

Ending:

10/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,692)	0	0	0	0	0	0	0	0	0	0	(1,692)	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	(18,852)	0	0	0	0	0	0	0	0	0	0	(18,852)	6
7	Other (specify):*	0	(761,264)	0	0	0	0	0	0	0	0	0	(761,264)	7
8	TOTAL General Services	(20,544)	(761,264)	0	0	0	0	0	0	0	0	0	(781,808)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(361,318)	0	0	0	0	0	0	0	0	0	(361,318)	15
16	TOTAL Health Care and Programs	0	(361,318)	0	0	0	0	0	0	0	0	0	(361,318)	16
	C. General Administration													
17	Administrative	(221,808)	0	0	0	0	0	0	0	0	0	0	(221,808)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(19,562)	0	0	0	0	0	0	0	0	0	0	(19,562)	20
21	Clerical & General Office Expenses	0	(36,072)	0	0	0	0	0	0	0	0	0	(36,072)	21
22	Employee Benefits & Payroll Taxes	(6,318)	0	0	0	0	0	0	0	0	0	0	(6,318)	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	22,695	0	0	0	0	0	0	0	0	0	22,695	26
27	Other (specify):*	0	(512,197)	0	0	0	0	0	0	0	0	0	(512,197)	27
28	TOTAL General Administration	(247,688)	(525,574)	0	0	0	0	0	0	0	0	0	(773,262)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(268,232)	(1,648,156)	0	0	0	0	0	0	0	0	0	(1,916,388)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2005 Ending:

10/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	6,847	0	0	0	0	0	0	0	0	0	0	6,847	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(116,373)	0	0	0	0	0	0	0	0	0	0	(116,373)	32
33	Real Estate Taxes	0	0	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	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	(467,208)	0	0	0	0	0	0	0	0	0	(467,208)	36
37	TOTAL Ownership	(109,526)	(467,208)	0	0	0	0	0	0	0	0	0	(576,734)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(377,758)	(2,115,364)	0	0	0	0	0	0	0	0	0	(2,493,122)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>SLOVAK AMERICAN CHARITABLE ASSOCIATION</u>	<u>100</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>
<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>ROLLING HILLS PLACE</u>	<u>ZION, ILLINOIS</u>	<u>ASSISTED LIVING FACILITY</u>

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			
<u>1</u>	<u>V</u>	<u>21 ADMINISTRATIVE EXPENSES</u>	<u>\$ 36,072</u>	<u>SLOVAK AMERICAN CHARITABLE ASSOCIATION</u>	<u>100.00%</u>	<u>\$</u>	<u>\$</u>	<u>(36,072)</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>26 LIABILITY INSURANCE</u>	<u>(22,695)</u>	<u>SLOVAK AMERICAN CHARITABLE ASSOCIATION</u>	<u>100.00%</u>	<u>\$</u>	<u>\$</u>	<u>22,695</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>7 GENERAL SERVICES</u>	<u>761,264</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>\$</u>	<u>\$</u>	<u>(761,264)</u>	<u>3</u>
<u>4</u>	<u>V</u>	<u>15 HEALTHCARE & PROGRAMS</u>	<u>361,318</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>\$</u>	<u>\$</u>	<u>(361,318)</u>	<u>4</u>
<u>5</u>	<u>V</u>	<u>27 GENERAL ADMINISTRATION</u>	<u>512,197</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>\$</u>	<u>\$</u>	<u>(512,197)</u>	<u>5</u>
<u>6</u>	<u>V</u>	<u>36 CAPITAL EXPENSES</u>	<u>467,208</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>\$</u>	<u>\$</u>	<u>(467,208)</u>	<u>6</u>
<u>7</u>	<u>V</u>								<u>7</u>
<u>8</u>	<u>V</u>								<u>8</u>
<u>9</u>	<u>V</u>								<u>9</u>
<u>10</u>	<u>V</u>								<u>10</u>
<u>11</u>	<u>V</u>								<u>11</u>
<u>12</u>	<u>V</u>								<u>12</u>
<u>13</u>	<u>V</u>								<u>13</u>
<u>14</u>	<u>Total</u>		<u>\$ 2,115,364</u>			<u>\$</u>	<u>\$ *</u>	<u>(2,115,364)</u>	<u>14</u>

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

Facility Name & ID Number

ROLLING HILLS MANOR

#

0025239

Report Period Beginning:

11/01/2005

Ending:

10/31/2006

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	ANNE LESAK SCOTT	DIRECTOR	PRESIDENT	NONE	NONE	1/2 HR.	2.00	DIR. FEE	\$ 1,875	18/	1
2	ANNE LESAK SCOTT	DIRECTOR	NURSING ADV.	NONE	NONE	1/2 HR.	2.00	NURS. ADV.	411	18	2
3	ANNE MEDO	DIRECTOR	TREASURER	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,500	18	3
4	JAMES STEFO, JR.	DIRECTOR	SECRETARY	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,750	18	4
5	ELEANOR PETRAS	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,750	18	5
6	JANET PILCH	DIRECTOR	VICE PRES.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,625	18	6
7	JANA CHARVAT	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,375	18	7
8	GEORGE JANAC	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	750	18	8
9	GEORGE JANAC	DIRECTOR	BUSINESS MGR.	NONE	NONE	8.00 HRS.	20.00	BUD. MGR.	1,500	18	9
10											10
11											11
12											12
13								TOTAL	\$ 12,536		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: **11/01/2005** Ending: **0/31/2006**

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	N/A				\$	\$		\$	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:

11/01/2005

Ending:

10/31/2006

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										
										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		X	REFINANCING OF SERIES			\$	\$			\$	1								
2	IDFA REVENUE BONDS		1991 REVENUE BONDS	\$9,750.00	6/29/2000	2,600,000	2,378,049	6/29/2030	VAR.	81,042	2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$9,750.00		\$ 2,600,000	\$ 2,378,049			\$ 81,042	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	\$ 2,378,049			\$ 81,042	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.)

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2005 Ending:

10/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,632 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories ONE

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ROLLING HILLS PLACE
ASSISTED LIVING FACILITY
48000 SQUARE FEET
69 BEDS / 61 UNITS

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>3 ACRES</u>	<u>1979</u>	<u>\$ 100,763</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	3 ACRES		\$ 100,763	3

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

Report Period Beginning:

11/01/2005 Ending: 10/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	127		1979	1970	\$ 927,078	\$ 10,896	40	\$ 17,743	\$ 6,847	\$ 818,119	4
5		PREMIUM PAID UPON ACQUISITION	1979	1970	712,648	20,362	35	20,362		549,756	5
6		RENOVATIONS	1992	1992	1,234,270	30,857	40	30,857		447,423	6
7		RENOVATIONS	1992	1992	232,299		10			232,299	7
8		RENOVATIONS	1998	1998	695,702	17,393	40	17,393		139,908	8
		Improvement Type**									
9		AIRLOCK		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		AIR CONDITIONING UNITS		1984	37,141		10			37,141	13
14		HEATING UNITS		1985	1,061		10			1,061	14
15		RAMP		1985	38,992	10	20	10		38,992	15
16		MIXING VALVE		1985	325		20			325	16
17		FENCE		1986	1,257	27	20	27		1,257	17
18		RAMP		1986	5,400	135	20	135		5,395	18
19		ROOF		1986	33,997	814	20	814		33,947	19
20		HEATING UNITS		1988	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		10			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	731	20	731		9,871	28
29		ROOF		1994	24,500		10			24,500	29
30		HEATING UNITS		1994	6,987		10			6,987	30
31		WATERLINE		1994	6,820	341	20	341		4,263	31
32		PARKING LOT SURFACE		1994	4,346	217	20	217		1,998	32
33		ROOF		1995	24,800		10			24,800	33
34		HOT WATER 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.

See Page 12A, Line 70 for total

**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:

11/01/2005 Ending: 10/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	\$ 716	10	\$ 716	\$	\$ 14,321	37
38	RETAINING WALL	1996	38,975	1,949	20	1,949		20,462	38
39	OXYGEN ENVIRONMENT	1996	3,892	113	10	113		3,892	39
40	EMERGENCY GENERATOR	1996	10,089	673	15	673		7,063	40
41	CANOPIES	1997	2,490	249	10	249		2,366	41
42	KITCHEN TILING	1997	3,507	356	10	356		3,361	42
43	AIR CONDITIONING UNIT	1997	5,970	597	10	597		5,672	43
44	ROOF	1998	5,500	550	10	550		4,675	44
45	SIGN	1999	2,768	69	40	69		553	45
46	SIGN	1999	4,668	117	40	117		934	46
47	PELLA WINDOWS	1999	7,855	393	20	393		2,946	47
48	CARPETING AND WALLPAPER	2000	9,279	761	10	761		4,910	48
49	SMOKE DETECTORS	2000	12,985	814	10	814		5,298	49
50	ROOF	2000	12,585	629	20	629		4,091	50
51	SEWER EXTENSION	2000	11,480	574	20	574		3,731	51
52	SHRUBBERY	2001	2,211	147	15	147		810	52
53	PAINT AND WALLPAPER	2001	1,510	151	10	151		831	53
54	VINYL FLOORING	2001	9,602	960	10	960		5,281	54
55	CARPETING	2001	17,556	1,756	10	1,756		9,657	55
56	HAND RAILS	2001	11,425	571	20	571		3,141	56
57	PRESSURE VALVE	2001	4,636	232	20	232		1,275	57
58	EXHAUST FANS	2001	3,994	200	20	200		1,099	58
59	CARPETING AND TILE	2002	80,772	8,077	10	8,077		36,347	59
60	HAND RAILS	2002	28,365	1,418	40	1,418		6,382	60
61	CLASSROOM FLOORS AND WALLS	2002	2,970	149	40	149		669	61
62	WOOD COLUMNS	2002	7,050	353	40	353		1,587	62
63	FLOOR OUTLETS	2002	4,606	230	40	230		1,036	63
64	DOORS	2002	7,360	368	40	368		1,656	64
65	VINYL FLOORING	2003	29,600	2,960	10	2,960		10,360	65
66	DOORS	2003	6,835	342	40	342		1,200	66
67	SIDEWALKS	2003	4,352	218	40	218		762	67
68	SHRUBBERY	2004	5,000	500	10	500		1,250	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,642,715	\$ 108,975		\$ 115,822	\$ 6,847	\$ 2,811,920	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:

11/01/2005 Ending: 10/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	\$ 108,975		\$ 115,822	\$ 6,847	\$ 2,811,920	1
2	CARPETING	2004	27,900	2,790	10	2,790		6,975	2
3	DOORS	2004	11,800	590	20	590		1,475	3
4	DOORS	2005	3,372	168	20	168		252	4
5	WALLGUARDS AND RAILS	2005	3,540	354	10	354		531	5
6	VENTILATION DAMPERS	2005	3,538	236	15	236		354	6
7	DOOR PLATES AND LOCKS	2005	3,525	176	20	176		264	7
8	SIGNS	2005	3,662	366	10	366		549	8
9	SENSOR SECURITY SYSTEM	2005	24,322	1,216	20	1,216		1,824	9
10	TELEPHONE CIRCUITRY	2005	5,483	365	15	365		548	10
11	FLOORING	2005	1,500	150	10	150		225	11
12	ALARM SYSTEM	2005	1,527	153	10	153		229	12
13	TELEPHONE CIRCUITRY	2005	2,163	144	15	144		216	13
14	WATERLINES AND BOILER	2005	33,140	1,657	20	1,657		2,486	14
15	HVAC UNIT	2005	9,280	238	39	238		258	15
16	HVAC UNIT	2005	7,925	792	10	792		1,188	16
17	FLOORING	2005	7,148	715	10	715		1,073	17
18	ELECTRIC PANEL	2006	1,100	28	20	28		28	18
19	FREEZER CIRCUITRY	2006	1,986	66	15	66		66	19
20	100 WING REVOVATIONS	2006	32,095	802	20	802		802	20
21	ELEVATOR RENOVATIONS	2006	33,276	832	20	832		832	21
22	DOOR LOCKS	2006	1,830	46	20	46		46	22
23	CRASH RAILS	2006	578	14	20	14		14	23
24	BOILER PIPING	2006	1,742	44	20	44		44	24
25	SKYLIGHTS	2006	3,205	80	20	80		80	25
26	SIDEWALKS	2006	1,400	35	20	35		35	26
27	100 WING REVOVATIONS	2006	11,995	300	20	300		300	27
28	GENERATOR ELECTRICAL	2006	1,336	67	10	67		67	28
29	PARKING LOT SURFACE	2006	2,985	299	5	299		299	29
30	ELEVATOR LIGHTING	2006	1,527	25	20	25		25	30
31	WALK IN FREEZER	2006	33,813	845	20	845		845	31
32	SHRUBBERY	2003	4,512	169	10	169		169	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,925,920	\$ 122,737		\$ 129,584	\$ 6,847	\$ 2,834,019	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 87,673	\$ 4,953	\$ 4,953	\$	7-10 YRS	\$ 4,953	71
72	Current Year Purchases	582,749	62,224	62,224		7-10 YRS	330,814	72
73	Fully Depreciated Assets	1,093,979	5,545	5,545		7-10 HRS	1,093,979	73
74								74
75	TOTALS	\$ 1,764,401	\$ 72,722	\$ 72,722	\$		\$ 1,429,746	75

D. Vehicle Depreciation (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	1995 FORD ELDORADO	1995	\$ 40,018	\$	\$	\$		\$ 40,018	76
77										77
78										78
79										79
80	TOTALS			\$ 40,018	\$	\$	\$		\$ 40,018	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)	\$ 6,831,102	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,459	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 202,306	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,847	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,303,783	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	\$ NONR	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	\$	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								5
6								6
7	TOTAL		N/A		\$ 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 _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	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>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Contract	Total
		1 Drop-outs	2 Completed		
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	10a	hrs	\$		\$ 295,920	\$		\$ 295,920	1
2	Licensed Speech and Language Development Therapist	10a	hrs			43,107			43,107	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs			313,252			313,252	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	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 652,279	\$		\$ 652,279	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 **ROLLING HILLS MANOR**# **0025239**Report Period Beginning: **11/01/2005**

Ending:

10/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **10/31/2006**

(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	\$ 418,842	\$ 618,914	1
2	Cash-Patient Deposits	10,696	10,696	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>220,000</u>)	1,007,767	1,023,207	3
4	Supply Inventory (priced at <u>COST</u>)	113,154	143,785	4
5	Short-Term Investments		22,704	5
6	Prepaid Insurance	31,126	39,067	6
7	Other Prepaid Expenses	71,822	140,860	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,653,407	\$ 1,999,233	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,380,316	12
13	Land	100,763	236,453	13
14	Buildings, at Historical Cost	4,925,920	11,211,235	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,804,419	2,538,515	16
17	Accumulated Depreciation (book methods)	(4,303,783)	(5,449,745)	17
18	Deferred Charges	163,880	411,380	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,691,199	\$ 10,328,154	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,344,606	\$ 12,327,387	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 186,846	\$ 217,009	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,696	10,696	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	305,561	323,379	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,911	21,797	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>RESIDEENT AND OTHER CREDITS</u>	98,221	239,637	36
37	<u>DUE ROLLING HILLS PLACE</u>	(73,607)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 534,628	\$ 812,518	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,378,049	7,500,000	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)	\$ 2,378,049	\$ 7,500,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,912,677	\$ 8,312,518	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,431,929	\$ 4,014,869	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,344,606	\$ 12,327,387	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,992,554	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,992,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	22,315	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)	\$ 22,315	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)	\$ 4,014,869	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**Report Period Beginning: **11/01/2005**Ending: **10/31/2006**

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,684,256	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,684,256	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,245,378	6
7	Oxygen	104,895	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,350,273	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	6,318	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	18,852	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)	\$ 25,170	23
D. Non-Operating Revenue			
24	Contributions	8,795	24
25	Interest and Other Investment Income***	191,468	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 200,263	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,259,962	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,113,543	31
32	Health Care	4,780,149	32
33	General Administration	2,489,265	33
B. Capital Expense			
34	Ownership	779,040	34
C. Ancillary Expense			
35	Special Cost Centers	6,116	35
36	Provider Participation Fee	69,534	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,237,647	40
41	Income before Income Taxes (line 30 minus line 40)**	22,315	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 22,315	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

0025239

Report Period Beginning:

11/01/2005

Ending:

10/31/2006

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	1,608	1,720	\$ 66,001	\$ 38.37	1
2	Assistant Director of Nursing	1,622	1,856	63,032	33.96	2
3	Registered Nurses	14,415	17,006	590,387	34.72	3
4	Licensed Practical Nurses	18,094	19,746	523,795	26.53	4
5	CNAs & Orderlies	91,726	97,889	1,426,650	14.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,761	7,347	112,622	15.33	8
9	Activity Director	1,672	1,888	40,525	21.46	9
10	Activity Assistants	4,883	5,300	59,559	11.24	10
11	Social Service Workers	3,145	3,470	67,994	19.59	11
12	Dietician					12
13	Food Service Supervisor	1,720	2,016	50,995	25.30	13
14	Head Cook	4,712	5,032	83,668	16.63	14
15	Cook Helpers/Assistants	18,447	19,837	163,433	8.24	15
16	Dishwashers					16
17	Director of Nursing	12,029	12,935	103,449	8.00	17
18	Housekeepers	28,415	30,657	303,449	9.90	18
19	Laundry	12,088	13,042	126,776	9.72	19
20	Administrator	1,582	1,878	76,805	40.90	20
21	Admissions Director	1,720	1,976	76,065	38.49	21
22	Other Administrative	7,265	8,186	146,676	17.92	22
23	Office Manager	1,792	1,976	53,699	27.18	23
24	Clerical	7,551	8,014	74,679	9.32	24
25	Executive Director	1,768	1,856	84,912	45.75	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,736	1,917	53,024	27.66	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,073	2,201	25,775	11.71	31
32	Medicare MDS Coordinator	1,768	1,976	55,308	27.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	248,592	269,721	\$ 4,429,278 *	\$ 16.42	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	1,348	\$ 33,640	1:3	35
36	Medical Director	115	8,650	9:3	36
37	Medical Records Consultant	25	1,880	10:3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	109	1,091	10a:3	40
41	Occupational Therapy Consultant	101	1,014	10a:3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	244	10a:3	43
44	Activity Consultant	17	426	11:3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,740	\$ 46,945		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	
CAROLYN LOFLAND	ADMINISTRATOR	NONE	\$ 76,805	Workers' Compensation Insurance	\$ 84,212	IDPH License Fee	\$	
JAMES STEFO, SR.	EXEC. DIRECTOR	NONE	84,912	Unemployment Compensation Insurance	18,581	Advertising: Employee Recruitment	6,951	
				FICA Taxes	326,507	Health Care Worker Background Check		
				Employee Health Insurance	336,172	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	19,562	
				Employee Life Insurance	13,707	Inspections and fees	4,161	
				PTO Expense	20,819	Memberships	777	
				Employee Retirement Funding	27,070	Life Service Network	6,050	
				Employee Severance Settlement	7,500			
						Less: Public Relations Expense	()	
						Non-allowable advertising	(11,804)	
						Yellow page advertising	(7,758)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 161,717	TOTAL (agree to Schedule V, line 22, col.8)	\$ 834,568	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,939	
(List each licensed administrator separately.)								
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			\$ 221,808			\$	Out-of-State Travel	\$
							Auto Expense	970
							Travel Reimbursement	2,528
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 221,808				Seminar Expense	7,544
(Attach a copy of any management service agreement)								
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount	\$ NONE			\$ 11,042	
Altschuler, Melvoin, and Glasser	Auditing Fees		28,485					
James S. Stefo and Co.	Accounting Fees		5,640					
Wessels amd Pautsch	Legal Fees		27,627					
Foley & Lardner	Legal Fees		5,451					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 67,203					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ROLLING HILLS MANOR# 0025239Report Period Beginning: 11/01/2005 Ending: 10/31/2006**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. LIFE SERVICE NETWORK \$6050.00
- (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. \$ 68,014 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 NO NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO NO NO 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. \$ 69,534
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. \$ 6,318 Has any meal income been offset against related costs? YES Indicate the amount. \$ 6,318
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: ALTSCHULER, MELVOIN, & GLASSER, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. AWAITING FINAL REPORT
- (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.

SCHEDULE V COLUMN 5 LINES 2 AND 22

\$6,318 OF EMPLOYEE MEALS HAVE BEEN DEDUCTED FROM LINE 2 (FOOD COSTS)
AND HAVE BEEN ADDED TO LINE 22 (EMPLOYEE BENEFITS).

SCHEDULE V COLUMN 5 LINES 10 AND 43

\$350,417 OF PRESCRIPTION DRUG COSTS HAVE BEEN DEDUCTED FROM
LINE 10 (NURSING COSTS) AND ADDED TO LINE 43 (SPECIAL COST CENTERS - OTHER).