



Facility Name & ID Number ROLLING HILLS MANOR

# 0025239 Report Period Beginning: 11/01/2008 Ending: 10/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<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				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>17,436</u>	<u>11,312</u>	<u>11,865</u>	<u>40,613</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>17,436</u>	<u>11,312</u>	<u>11,865</u>	<u>40,613</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.61%

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 09/01/1979

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 11,865

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: 10/31/2009 Fiscal Year: 10/31/2009

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

Facility Name & ID Number **ROLLING HILLS MANOR** # **0025239** Report Period Beginning: **11/01/2008** Ending: **10/31/2009**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	316,873	33,567	37,800	388,240		388,240		388,240		1
2	Food Purchase		211,915		211,915	(22,225)	189,690	(1,927)	187,763		2
3	Housekeeping	264,406	57,101		321,507		321,507		321,507		3
4	Laundry	154,816	21,736	10,628	187,180		187,180		187,180		4
5	Heat and Other Utilities			180,902	180,902		180,902		180,902		5
6	Maintenance	196,377	30,211	80,225	306,813		306,813		306,813		6
7	Other (specify):* <b>Rolling Hills Place</b>			788,697	788,697		788,697	(788,697)			7
8	<b>TOTAL General Services</b>	932,472	354,530	1,098,252	2,385,254	(22,225)	2,363,029	(790,624)	1,572,405		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			28,000	28,000		28,000		28,000		9
10	Nursing and Medical Records	4,005,750	149,766	569,324	4,724,840	(430,646)	4,294,194		4,294,194		10
10a	Therapy			1,132,278	1,132,278		1,132,278		1,132,278		10a
11	Activities	100,679	5,486	8,949	115,114		115,114		115,114		11
12	Social Services	76,436	847	6,001	83,284		83,284		83,284		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Rolling Hills Place</b>			443,264	443,264		443,264	(443,264)			15
16	<b>TOTAL Health Care and Programs</b>	4,182,865	156,099	2,187,816	6,526,780	(430,646)	6,096,134	(443,264)	5,652,870		16
	<b>C. General Administration</b>										
17	Administrative	182,375		87,622	269,997		269,997	(87,622)	182,375		17
18	Directors Fees			10,800	10,800		10,800		10,800		18
19	Professional Services			97,900	97,900		97,900		97,900		19
20	Dues, Fees, Subscriptions & Promotions			37,017	37,017		37,017	(13,137)	23,880		20
21	Clerical & General Office Expenses	408,282	39,053	154,759	602,094		602,094	(45,701)	556,393		21
22	Employee Benefits & Payroll Taxes			1,019,168	1,019,168	22,225	1,041,393	(6,813)	1,034,580		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,699	11,699		11,699		11,699		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			82,303	82,303		82,303	18,529	100,832		26
27	Other (specify):* <b>Rolling Hills Place</b>			674,661	674,661		674,661	(674,661)			27
28	<b>TOTAL General Administration</b>	590,657	39,053	2,175,929	2,805,639	22,225	2,827,864	(809,405)	2,018,459		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,705,994	549,682	5,461,997	11,717,673	(430,646)	11,287,027	(2,043,293)	9,243,734		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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			218,018	218,018		218,018	12,281	230,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			140,337	140,337		140,337	(54,508)	85,829			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>Rolling Hills Pl.</b>			529,598	529,598		529,598	(529,598)				36
37	<b>TOTAL Ownership</b>			887,953	887,953		887,953	(571,825)	316,128			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533		69,533		69,533			42
43	Other (specify):* <b>Scripton Drugs</b>						430,646		430,646			43
44	<b>TOTAL Special Cost Centers</b>			69,533	69,533	430,646	500,179		500,179			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,705,994	549,682	6,419,483	12,675,159		12,675,159	(2,615,118)	10,060,041			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,813)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,281	30		9
10	Interest and Other Investment Income	(54,508)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,927)	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	(87,622)	17		24
25	Fund Raising, Advertising and Promotional	(13,137)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (151,726)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,463,392)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (2,463,392)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,615,118)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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		430,646	10 43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 430,646	47

**BHF USE ONLY**

48		49		50		51		52	
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ROLLING HILLS MANOR

ID# 0025239

Report Period Beginning: 11/01/2008

Ending: 10/31/2009

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2008

Ending:

10/31/2009

## 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	(1,927)	0	0	0	0	0	0	0	0	0	0	(1,927)	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	(788,697)	0	0	0	0	0	0	0	0	0	(788,697)	7
8	<b>TOTAL General Services</b>	<b>(1,927)</b>	<b>(788,697)</b>	<b>0</b>	<b>(790,624)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(443,264)	0	0	0	0	0	0	0	0	0	(443,264)	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(443,264)</b>	<b>0</b>	<b>(443,264)</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	(87,622)	0	0	0	0	0	0	0	0	0	0	(87,622)	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	(13,137)	0	0	0	0	0	0	0	0	0	0	(13,137)	20
21	Clerical & General Office Expenses	0	(45,701)	0	0	0	0	0	0	0	0	0	(45,701)	21
22	Employee Benefits & Payroll Taxes	(6,813)	0	0	0	0	0	0	0	0	0	0	(6,813)	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	18,529	0	0	0	0	0	0	0	0	0	18,529	26
27	Other (specify):*	0	(674,661)	0	0	0	0	0	0	0	0	0	(674,661)	27
28	<b>TOTAL General Administration</b>	<b>(107,572)</b>	<b>(701,833)</b>	<b>0</b>	<b>(809,405)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(109,499)</b>	<b>(1,933,794)</b>	<b>0</b>	<b>(2,043,293)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2008 Ending:

Summary B

10/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	12,281	0	0	0	0	0	0	0	0	0	0	12,281	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(54,508)	0	0	0	0	0	0	0	0	0	0	(54,508)	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	(529,598)	0	0	0	0	0	0	0	0	0	(529,598)	36
37	<b>TOTAL Ownership</b>	<b>(42,227)</b>	<b>(529,598)</b>	<b>0</b>	<b>(571,825)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(151,726)</b>	<b>(2,463,392)</b>	<b>0</b>	<b>(2,615,118)</b>	<b>45</b>								

**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</u>	<u>Administrative Expenses</u>	<u>\$ 45,701</u>	<u>Slovak American Charitable Association</u>		<u>\$ (45,701)</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>26</u>	<u>Liability Insurance</u>	<u>(18,529)</u>	<u>Slovak American Charitable Association</u>		<u>18,529</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>7</u>	<u>General Services</u>	<u>788,697</u>	<u>Rolling Hills Place</u>		<u>(788,697)</u>	<u>3</u>
<u>4</u>	<u>V</u>	<u>15</u>	<u>Healthcare and Programs</u>	<u>443,264</u>	<u>Rolling Hills Place</u>		<u>(443,264)</u>	<u>4</u>
<u>5</u>	<u>V</u>	<u>27</u>	<u>General Administration</u>	<u>674,661</u>	<u>Rolling Hills Place</u>		<u>(674,661)</u>	<u>5</u>
<u>6</u>	<u>V</u>	<u>36</u>	<u>Capital Expenses</u>	<u>529,598</u>	<u>Rolling Hills Place</u>		<u>(529,598)</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>\$ 2,463,392</u>			<u>\$</u>	<u>\$ * (2,463,392)</u>	<u>14</u>

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

Facility Name &amp; ID Number

ROLLING HILLS MANOR

# 0025239

Report Period Beginning:

11/01/2008

Ending:

10/31/2009

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES STEFO, JR.	DIRECTOR	PRESIDENT	NONE	NONE	1/2 HR.	2.00	DIR. FEE	\$ 1,800	18.3	1
2	JANET PILCH	DIRECTOR	VICE PRES.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,500	18.3	2
3	ANN MEDO	DIRECTOR	TREASURER	NONE	NONE	1/2 HR.	2.00	DIR. FEE	600	18.3	3
4	DOROTHY MITCHELL	DIRECTOR	SECRETARY	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,800	18.3	4
5	ANNE LESAK SCOTT	DIRECTOR	MANG'T COMM	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,650	18.3	5
6	ELEANOR PETRAS	DIRECTOR	MANG'T COMM	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,650	18.3	6
7	MARION STEFO	DIRECTOR	MANG'T COMM	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,800	18.3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,800		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:

11/01/2008

Ending: 0/31/2009

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

Facility Name & ID Number

ROLLING HILLS MANOR

# 0025239

Report Period Beginning:

11/01/2008

Ending:

10/31/2009

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	<b>IDFA REVENUE BONDS</b>		<b>REFINANCING OF SERIES</b>			\$	\$			\$									
2	<b>SERIES 2000</b>	X	<b>1991 REVENUE BONDS</b>	<b>\$15,500.00</b>	<b>6/20//2000</b>	<b>2,600,000</b>	<b>2,211,585</b>	<b>6/29/2030</b>	<b>5.7500</b>	<b>128,729</b>									
3																			
4																			
5																			
<b>Working Capital</b>																			
6																			
7																			
8																			
9	<b>TOTAL Facility Related</b>			<b>\$15,500.00</b>		<b>\$ 2,600,000</b>	<b>\$ 2,211,585</b>			<b>\$ 128,729</b>									
<b>B. Non-Facility Related*</b>																			
10																			
11																			
12																			
13																			
14	<b>TOTAL Non-Facility Related</b>					<b>\$</b>	<b>\$</b>			<b>\$</b>									
15	<b>TOTALS (line 9+line14)</b>					<b>\$ 2,600,000</b>	<b>\$ 2,211,585</b>			<b>\$ 128,729</b>									

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	<b>NONE</b>	<b>1</b>
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.)		\$	<b>NONE</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>NONE</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>NONE</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>NONE</b>	<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>NONE</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>NONE</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>NONE</b>	<b>8</b>	
	2005	<b>NONE</b>	<b>9</b>	
	2006	<b>NONE</b>	<b>10</b>	
	2007	<b>NONE</b>	<b>11</b>	
	2008	<b>NONE</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**



Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2008 Ending:10/31/2009**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 51,632 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_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 PLACEASSISTED LIVING FACILITY69 BEDS / 61 UNITS48000 SQUARE FEETF. 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: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>3 ACRES</u>	<u>1979</u>	<u>\$ 100,762</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>3 ACRES</b>		<b>\$ 100,762</b>	<b>3</b>

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

Report Period Beginning:

11/01/2008 Ending:

10/31/2009

**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 BUFF 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	\$ 23,177	\$ 12,281	\$ 850,807	4
5		PREMIUM PAID UPON ACQUISITION	1979	1970	712,648	20,362	35	20,362		610,842	5
6		RENOVATIONS	1992	1992	1,234,270	30,857	40	30,857		539,994	6
7		RENOVATIONS	1992	1992	232,299		10			232,299	7
8		RENOVATIONS	1998	1998	695,702	17,393	40	17,393		192,087	8
		Improvement Type**									
9		AIRLOCK		1982	3,886					3,886	9
10		ROOF		1983	41,724					41,724	10
11		PLUMBING FIXTURES		1983	3,845					3,845	11
12		ROOF AND HEATER		1984	118,647					118,647	12
13		SURFACING AND DRAINAGE		1984	37,141					37,141	13
14		HEATING UNITS		1985	1,061					1,061	14
15		RAMP		1985	38,992					38,992	15
16		MIXING VALVE		1985	325					325	16
17		FENCE		1986	1,257					1,257	17
18		RAMP		1986	5,400					5,400	18
19		ROOF		1986	33,997					33,997	19
20		HEATING UNITS		1988	6,344					6,344	20
21		FLOOD DEVICE		1989	7,418					7,418	21
22		ELECTRIC PANELS		1989	6,354					6,354	22
23		HALLWAY LIGHTING		1990	8,091					8,091	23
24		ALARM SYSTEM		1991	6,775					6,775	24
25		PELLA WINDOWS		1992	4,367					4,367	25
26		PELLA WINDOWS		1992	3,661					3,661	26
27		ROOF		1993	24,500					24,500	27
28		PELLA WINDOWS		1993	14,624	731		731		12,064	28
29		ROOF		1994	24,500					24,500	29
30		HEATING UNITS		1994	6,987					6,987	30
31		WATER LOYNE		1994	6,820	341		341		5,286	31
32		PARKING LOT SURFACE		1994	4,346	217		217		2,649	32
33		ROOF		1995	24,800					24,800	33
34		HOT WATER SYSTEM		1995	18,175					18,175	34
35		DOOR LOCKS		1995	12,473					12,473	35
36											36

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

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

See Page 12A, Line 70 for total

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

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

# **0025239**

Report Period Beginning:

11/01/2008

Ending:

10/31/2009

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CALL LIGHTING SYSTEM	1996	\$ 14,321	\$	10	\$	\$	\$ 14,321	37
38	RETAINING WALL	1996	38,975	1,949	20	1,949		26,309	38
39	OXYGEN ENVIRONMENT	1996	3,892		10			3,892	39
40	EMERGENCY GENERATOR	1996	10,089	673	15	673		9,082	40
41	CANOPIES	1997	2,490		10			2,490	41
42	KITCHEN TILING	1997	3,507		10			3,507	42
43	AIR CONDITIONING	1997	5,970		10			5,970	43
44	ROOF	1998	5,500	275	10	275		5,500	44
45	SIGN	1999	2,768	69	40	69		760	45
46	SIGN	1999	4,668	117	40	117		1,285	46
47	PELLA WINDOWS	1999	7,855	393	20	393		4,125	47
48	CARPETING AND WALLPAPER	2000	9,279	761	10	761		7,193	48
49	SMOKE DETECTORS	2000	12,985	814	10	814		7,740	49
50	ROOF	2000	12,585	629	20	629		5,978	50
51	SEWER EXTENSION	2000	11,480	574	20	574		5,453	51
52	SHRUBBERY	2001	2,211	147	15	147		1,251	52
53	PAINT AND WALLPAPER	2001	1,510	151	10	151		1,284	53
54	VINYL FLOORING	2001	9,602	960	10	960		8,161	54
55	CARPETING	2001	17,556	1,756	10	1,756		14,925	55
56	HAND RAILS	2001	11,425	571	20	571		4,854	56
57	PRESSURE VALVE	2001	4,636	232	20	232		1,971	57
58	EXHAUST FANS	2001	3,994	200	20	200		1,699	58
59	CARPETING AND TILE	2002	80,772	8,077	10	8,077		60,578	59
60	HAND RAILS	2002	28,365	1,418	40	1,418		10,636	60
61	CLASSROOM FLOORS AND WALLS	2002	2,970	149	40	149		1,116	61
62	WOOD COLUMNS	2002	7,050	353	40	353		2,646	62
63	FLOOR OUTLETS	2002	4,606	230	40	230		1,726	63
64	DOOR	2002	7,360	368	40	368		2,760	64
65	VINYL FLOORING	2003	29,600	2,960	10	2,960		19,240	65
66	DOORS	2003	6,835	342	40	342		2,226	66
67	SIDEWALKS	2003	4,352	218	40	218		1,416	67
68	SHRUBBERY	2004	5,000	500	10	500		2,750	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,642,715	\$ 105,683		\$ 117,964	\$ 12,281	\$ 3,129,592	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:

**11/01/2008**

Ending:

**10/31/2009****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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,642,715	\$ 105,683		\$ 117,964	\$ 12,281	\$ 3,129,592	1
2	<b>CARPETING</b>	2004	27,900	2,790	10	2,790		15,345	2
3	<b>DOORS</b>	2004	11,800	590	20	590		3,245	3
4	<b>DOORS</b>	2005	3,372	169	20	169		758	4
5	<b>WALL GUARDS AND RAILS</b>	2005	3,540	354	10	354		1,593	5
6	<b>VENTILATING DAMPERS</b>	2005	3,538	236	15	236		1,062	6
7	<b>DOOR PLATES AND LOCKS</b>	2005	3,525	176	20	176		792	7
8	<b>SIGNS</b>	2005	3,662	366	10	366		1,647	8
9	<b>SENSOR SECURITY SYSTEM</b>	2005	24,322	1,216	20	1,216		5,472	9
10	<b>TELEPHONE CIRCUITRY</b>	2005	5,483	366	15	366		1,645	10
11	<b>FLOORING</b>	2005	1,500	150	10	150		675	11
12	<b>ALARM SYSTEM</b>	2005	1,527	153	10	153		688	12
13	<b>TELEPHONE CIRCUITRY</b>	2005	2,163	144	15	144		648	13
14	<b>WATER LINES AND BOILER</b>	2005	33,140	1,657	20	1,657		7,457	14
15	<b>HVAC UNIT</b>	2005	9,280	238	39	238		972	15
16	<b>HVAC UNIT</b>	2005	7,925	793	10	793		3,566	16
17	<b>FLOORING</b>	2006	7,148	715	10	715		3,218	17
18	<b>ELECTRIC PANEL</b>	2006	1,100	55	20	55		193	18
19	<b>FREEZER CIRCUITRY</b>	2006	1,986	132	15	132		462	19
20	<b>ELEVATOR HYDRAULIC RENOVATIONS</b>	2006	33,276	1,664	20	1,664		5,824	20
21	<b>DOOR LOCKS</b>	2006	1,830	92	20	92		322	21
22	<b>CRASH RAILS</b>	2006	578	29	20	29		101	22
23	<b>BOILER PIPING</b>	2006	1,742	87	20	87		305	23
24	<b>SKYLIGHTS</b>	2006	3,205	160	20	160		560	24
25	<b>SIDEWALKS</b>	2006	1,400	70	20	70		245	25
26	<b>GENERATOR ELECTRIC SYSTEM</b>	2006	1,336	134	10	134		469	26
27	<b>PARKING LOT SURFACING</b>	2006	2,985	597	5	597		2,090	27
28	<b>ELEVATOR LIGHTING</b>	2006	1,527	76	20	76		253	28
29	<b>WALK IN FREEZER</b>	2006	33,813	1,691	20	1,691		5,918	29
30	<b>SHRUBBERY</b>	2006	4,512	451	10	451		1,409	30
31	<b>100 WING - ELECTRICAL</b>	2006	18,869	943	20	943		3,301	31
32	<b>100 WING - LIGHTING</b>	2006	4,106	205	20	205		717	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,904,805	\$ 122,182		\$ 134,463	\$ 12,281	\$ 3,200,544	34

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

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

Report Period Beginning:

**11/01/2008**

Ending:

**10/31/2009****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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,904,805	\$ 122,182		\$ 134,463	\$ 12,281	\$ 3,200,544	1
2	<b>100 WING - CARPENTRY AND DOORS</b>	2006	6,625	331	20	331		1,158	2
3	<b>100 WING - FLOORING</b>	2006	4,550	228	20	228		798	3
4	<b>100 WING - PLUMBING</b>	2006	1,742	88	20	88		308	4
5	<b>100 WING - PAINTING AND WALLPAPER</b>	2006	8,198	410	20	410		1,435	5
6	<b>SEWERS</b>	2007	31,553	1,578	20	1,578		3,945	6
7	<b>PLUMBING CONNECTIONS</b>	2007	3,384	169	20	169		423	7
8	<b>SPRINKLER SYSTEM</b>	2007	31,188	1,551	20	1,551		3,920	8
9	<b>KITCHEN TILING</b>	2007	1,420	142	10	142		355	9
10	<b>THERMOSTATS</b>	2007	3,585	358	10	358		895	10
11	<b>DOORS AND LOCKS</b>	2007	12,180	609	20	609		1,543	11
12	<b>WINDOW TREATMENTS</b>	2007	1,800	180	10	180		450	12
13	<b>COLUMN CAPS</b>	2007	7,534	462	20	462		1,155	13
14	<b>ROOFING</b>	2007	1,050	53	20	53		131	14
15	<b>AUTOMATIC DOORS</b>	2007	2,972	149	20	149		372	15
16	<b>ELECTRICAL PANEL</b>	2007	9,128	456	20	456		1,140	16
17	<b>HAND RAILS</b>	2007	3,200	160	20	160		400	17
18	<b>100 WING - LIGHTING</b>	2007	5,450	272	20	272		680	18
19	<b>100 WING - DOORS</b>	2007	3,885	194	20	194		485	19
20	<b>100 WING - PAINTING AND WALLPAPER</b>	2007	1,596	80	20	80		200	20
21	<b>FIRE ALARM SYSTEM</b>	2008	15,772	789	20	789		1,183	21
22	<b>AIR CONDITIONING UNIT</b>	2008	1,700	170	10	170		255	22
23	<b>WATER LINE</b>	2008	14,210	474	30	474		711	23
24	<b>CIRCUIT BREAKERS</b>	2008	1,140	57	20	57		85	24
25	<b>HEAT PUMP</b>	2008	6,525	653	10	653		979	25
26	<b>KITCHEN TILING</b>	2008	1,018	51	20	51		76	26
27	<b>SPRINKLER SYSTEM</b>	2008	3,986	199	20	199		299	27
28	<b>STORAGE ROOM DOORS</b>	2008	12,170	609	20	609		913	28
29	<b>CARPETING</b>	2008	2,825	283	10	283		424	29
30	<b>CARPETING</b>	2008	2,580	258	10	258		387	30
31	<b>WALL PANELS</b>	2008	3,267	163	20	163		245	31
32	<b>MAINTENANCE SINK</b>	2008	965	48	20	48		72	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,112,003	\$ 133,406		\$ 145,687	\$ 12,281	\$ 3,225,966	34

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

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

Report Period Beginning:

**11/01/2008**

Ending:

**10/31/2009****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	<b>Totals from Page 12C, Carried Forward</b>		\$ 5,112,003	\$ 133,406		\$ 145,687	\$ 12,281	\$ 3,225,966	1
2	<b>SPRINKLER SYSTEM</b>	2008	1,155	30	39	30		58	2
3	<b>STORAGE ROOM DOORS</b>	2008	3,958	101	39	101		200	3
4	<b>DOOR LOCKS</b>	2008	3,358	168	20	168		252	4
5	<b>BOILER AND WATER TANKS</b>	2008	11,920	596	20	596		892	5
6	<b>RETAINING WALL</b>	2008	46,418	2,321	20	2,321		3,411	6
7	<b>DOORS AND LOCKS</b>	2008	1,939	97	20	97		145	7
8	<b>DRYER EXHAUST VENTS</b>	2008	4,313	431	10	431		647	8
9	<b>CARPETING</b>	2008	3,600	360	10	360		540	9
10	<b>LANDSCAPING AND SHRUBBERY</b>	2008	18,783	939	20	939		1,409	10
11	<b>ELEVATOR - ELECTRICAL</b>	2009	58,435	749	39	749		749	11
12	<b>WATER LINE PIPING</b>	2009	15,146	194	39	194		194	12
13	<b>FIRE ALARM SYSTEM</b>	2009	15,302	229	39	229		229	13
14	<b>SKYLIGHTS</b>	2009	9,175	229	20	229		229	14
15	<b>FLOORING</b>	2009	2,092	105	10	105		105	15
16	<b>FIRE ALARM SYSTEM</b>	2009	5,273	68	39	68		68	16
17	<b>NURSE CALL STATION SYSTEM</b>	2009	5,186	66	39	66		66	17
18	<b>TELEPHONE LINES</b>	2009	3,810	191	10	191		191	18
19	<b>LOBBY AND WALKWAY CARPETING</b>	2009	30,000	1,000	15	1,000		1,000	19
20	<b>LOBBY RENOVATIONS</b>	2009	60,684	2,003	15	2,003		2,003	20
21	<b>A/C COMPRESSOR</b>	2009	3,348	167	10	167		167	21
22	<b>PLUMBING AND HOT WATER TANK</b>	2009	5,532	70	39	70		70	22
23	<b>FIRE ALARM SYSTEM</b>	2009	758	10	39	10		10	23
24	<b>DRIVE WAY TO ROUTE 173</b>	2009	119,776	1,536	39	1,536		1,536	24
25	<b>PARKING LOT PAVING</b>	2009	8,499	283	15	283		283	25
26	<b>PARKING LOT STRIPPING</b>	2009	4,495	150	15	150		150	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,554,958	\$ 145,499		\$ 157,780	\$ 12,281	\$ 3,240,570	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	\$ 724,070	\$	\$	\$	5 -10 YRS.	\$ 475,555
72	Current Year Purchases	46,095	4,567	4,567		5 -10 YRS.	4,567
73	Fully Depreciated Assets	1,165,275	1,040	1,040		5 -10 YRS.	1,165,275
74						5 -10 YRS.	
75	TOTALS	\$ 1,935,440	\$ 5,607	\$ 5,607	\$		\$ 1,645,397

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	\$	\$	\$	7 YRS	\$ 40,018
77									
78									
79									
80	TOTALS			\$ 40,018	\$	\$	\$		\$ 40,018

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)	\$ 7,631,178
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,106
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 163,387
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,281
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,925,985

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		\$
93		
94		
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.

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**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				\$ _____			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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**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	<b>TOTALS</b>	\$	\$ NONE	\$ NONE	\$ NONE
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	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)	
<b>TOTAL TRAINED</b>	<b>NONE</b>

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 526,991	\$		\$ 526,991	1
2	Licensed Speech and Language Development Therapist		hrs			50,489			50,489	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			554,798			554,798	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 1,132,278	\$		\$ 1,132,278	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: **11/01/2008**Ending: **10/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **10/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 617,429	\$ 979,635	1
2	Cash-Patient Deposits	10,745	10,745	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u> )	913,771	938,118	3
4	Supply Inventory (priced at )	187,868	231,465	4
5	Short-Term Investments			5
6	Prepaid Insurance	24,547	24,547	6
7	Other Prepaid Expenses	65,380	143,374	7
8	Accounts Receivable (owners or related parties)	(69,438)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,750,302	\$ 2,327,884	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,315,384	12
13	Land	100,762	236,453	13
14	Buildings, at Historical Cost	5,554,958	12,129,194	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,975,458	2,750,691	16
17	Accumulated Depreciation (book methods)	(4,925,985)	(6,749,881)	17
18	Deferred Charges	155,596	399,165	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (A/R Settlement Claim)	117,381	117,381	22
23	Other(specify): <u>Deferred Planning Costs</u>		43,568	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,978,170	\$ 10,241,955	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,728,472	\$ 12,569,839	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 376,548	\$ 405,715	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,745	10,745	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	461,784	489,854	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	8,546	28,953	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Resident and other credits</u>	86,433	264,833	36
37	<u>LSN Retro Insurance Payable</u>	57,241	57,241	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,001,297	\$ 1,257,341	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,211,585	6,975,000	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,211,585	\$ 6,975,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,212,882	\$ 8,232,341	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,515,590	\$ 4,337,498	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,728,472	\$ 12,569,839	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,706,260</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,706,260</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>631,238</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>631,238</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,337,498</b>	<b>24</b> *

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

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**Report Period Beginning: **11/01/2008**Ending: **10/31/2009**

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,915,441	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,915,441	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,078,309	6
7	Oxygen	88,136	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,166,445	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,813	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,813	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	16,519	24
25	Interest and Other Investment Income***	54,508	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 71,027	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Realized loss on investments	(292,297)	28
28a	Unrealized gain on investments	438,968	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 146,671	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,306,397	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,385,254	31
32	Health Care	6,526,780	32
33	General Administration	2,805,639	33
<b>B. Capital Expense</b>			
34	Ownership	887,953	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	69,533	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,675,159	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	631,238	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 631,238	43

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

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

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

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

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

# **0025239**

Report Period Beginning:

**11/01/2008**

Ending:

**10/31/2009**

**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	1,968	2,240	\$ 78,918	\$ 35.23	1
2	Assistant Director of Nursing	1,856	2,160	69,093	31.99	2
3	Registered Nurses	38,846	42,507	1,288,932	30.32	3
4	Licensed Practical Nurses	17,780	19,819	500,999	25.28	4
5	CNAs & Orderlies	141,810	152,903	1,872,402	12.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,526	6,517	99,389	15.25	8
9	Activity Director	1,952	2,200	44,841	20.38	9
10	Activity Assistants	5,610	5,995	55,838	9.31	10
11	Social Service Workers	3,640	4,080	76,436	18.73	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,289	54,294	23.72	13
14	Head Cook	4,194	4,869	96,886	19.90	14
15	Cook Helpers/Assistants	20,240	22,301	165,693	7.43	15
16	Dishwashers					16
17	Maintenance Workers	12,922	14,546	196,377	13.50	17
18	Housekeepers	26,125	28,865	264,406	9.16	18
19	Laundry	15,096	16,915	154,816	9.15	19
20	Administrator	1,888	2,160	84,907	39.31	20
21	Assistant Administrator					21
22	Other Administrative	9,970	10,868	163,493	15.04	22
23	Office Manager	1,996	2,280	62,205	27.28	23
24	Clerical	10,044	11,017	182,584	16.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,824	2,170	66,272	30.54	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,099	2,242	29,745	13.27	31
32	Other Health Care(specify)					32
33	Other(specify) <b>Executive Direct</b>	1,904	2,160	97,468	45.12	33
34	TOTAL (lines 1 - 33)	329,266	361,103	\$ 5,705,994 *	\$ 15.80	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	1,512	\$ 37,800	1;3	35
36	Medical Director	375	28,000	9;3	36
37	Medical Records Consultant	62	1,536	10:3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	62	3,109	10:3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	810	11:3	44
45	Social Service Consultant	171	6,001	12:3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,214	\$ 77,256		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	\$ 84,907	Workers' Compensation Insurance	\$ 173,301	IDPH License Fee	\$	
James S. Stefo, Sr.	Executive Director	None	97,468	Unemployment Compensation Insurance	1,150	Advertising: Employee Recruitment	2,371	
				FICA Taxes	414,841	Health Care Worker Background Check		
				Employee Health Insurance	351,789	(Indicate # of checks performed)		
				Employee Meals	22,225	Patient Background Checks	5,216	
				Illinois Municipal Retirement Fund (IMRF)*		Life Service Network	3,898	
				Employee Life Insurance	8,650	AAHSA	2,681	
				PTO Expense	13,537	Memberships	732	
				Employee Retirement Funding	55,900	Advertising	19,479	
				Employee Meal Reimbursement	(6,813)	Inspections and Fees	2,640	
						Less: Public Relations Expense		
						Non-allowable advertising	(13,137)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 182,375	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 1,034,580		\$ 23,880		
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			\$ 87,622			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 87,622				Automotive Expense	3,032
(Attach a copy of any management service agreement)							Travel Reimbursement	1,863
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type		Amount	\$ NONE			6,804	
James S. Stefo & Co.	Accounting		\$ 7,020					
Polsinelli Shalton	Legal		25,435					
Wessels Sherman	Legal		12,724					
Smith Amundsen	Legal		4,878					
Kutak Rock	Legal		1,500					
McGladrey & Pullen	Auditing		35,105					
Frost Ruttenberg	Auditing		11,238					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 97,900				Entertainment Expense ( )	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL \$ 11,699	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number ROLLING HILLS MANOR# 0025239Report Period Beginning: 11/01/2008Ending: 10/31/2009**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. LSN \$3,898 AAHSA \$2,681
- (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. \$ 62,660 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. \$ 69,533  
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. \$ 22,225 Has any meal income been offset against related costs? YES Indicate the amount. \$ 6,813
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ NONE**
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: McGladrey and Pullen
- (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

\$22,225 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

\$430,646 OF PRESCRIPTION DRUG COSTS HAVE BEEN DEDUCTED FROM LINE 10  
(NURSING COSTS) AND HAVE BEEN ADDED TO LINE 43 (SPECIAL COST CENTERS).