

Facility Name & ID Number ROLLING HILLS MANOR

0025239 Report Period Beginning: 11/01/2009 Ending: 10/31/2010

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<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>18,440</u>	<u>11,096</u>	<u>12,200</u>	<u>41,736</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>18,440</u>	<u>11,096</u>	<u>12,200</u>	<u>41,736</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.04%

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 09/01/1979 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 12,200

Medicare Intermediary WPS Medicare

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/2010 Fiscal Year: 10/31/2010

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

Facility Name & ID Number **ROLLING HILLS MANOR** # **0025239** Report Period Beginning: **11/01/2009** Ending: **10/31/2010**

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
	A. General Services										
1	Dietary	323,127	39,325	39,379	401,831		401,831		401,831		1
2	Food Purchase		219,073		219,073	(22,976)	196,097	(2,027)	194,070		2
3	Housekeeping	252,340	54,864		307,204		307,204		307,204		3
4	Laundry	171,571	14,152	38,006	223,729		223,729		223,729		4
5	Heat and Other Utilities			199,334	199,334		199,334		199,334		5
6	Maintenance	160,479	28,864	82,358	271,701		271,701		271,701		6
7	Other (specify):* Rolling Hills Place			873,179	873,179		873,179	(873,179)			7
8	TOTAL General Services	907,517	356,278	1,232,256	2,496,051	(22,976)	2,473,075	(875,206)	1,597,869		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	4,060,946	186,878	679,832	4,927,656	(530,939)	4,396,717		4,396,717		10
10a	Therapy			1,390,859	1,390,859		1,390,859		1,390,859		10a
11	Activities	110,082	3,490	8,135	121,707		121,707		121,707		11
12	Social Services	76,389	1,437	10,564	88,390		88,390		88,390		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Rolling Hills Place			440,706	440,706		440,706	(440,706)			15
16	TOTAL Health Care and Programs	4,247,417	191,805	2,548,096	6,987,318	(530,939)	6,456,379	(440,706)	6,015,673		16
	C. General Administration										
17	Administrative	197,671		54,144	251,815		251,815	(54,144)	197,671		17
18	Directors Fees			11,100	11,100		11,100		11,100		18
19	Professional Services			115,375	115,375		115,375		115,375		19
20	Dues, Fees, Subscriptions & Promotions			62,970	62,970		62,970	(18,405)	44,565		20
21	Clerical & General Office Expenses	411,736	43,337	176,434	631,507		631,507	(48,440)	583,067		21
22	Employee Benefits & Payroll Taxes			1,017,376	1,017,376	22,976	1,040,352	(6,364)	1,033,988		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,246	11,246		11,246		11,246		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			83,744	83,744		83,744	17,619	101,363		26
27	Other (specify):* Rolling Hills Place			650,893	650,893		650,893	(650,893)			27
28	TOTAL General Administration	609,407	43,337	2,183,282	2,836,026	22,976	2,859,002	(760,627)	2,098,375		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,764,341	591,420	5,963,634	12,319,395	(530,939)	11,788,456	(2,076,539)	9,711,917		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			232,368	232,768		232,768		232,768			30
31	Amortization of Pre-Op. & Org.											31
32	Interest and Bond Costs			123,661	123,661		123,661	(38,355)	85,306			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Rolling Hills Place			502,976	502,976		502,976	(502,976)				36
37	TOTAL Ownership			859,005	859,405		859,405	(541,331)	318,074			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533		69,533		69,533			42
43	Other (specify):* Perscription Drugs						530,939		530,939			43
44	TOTAL Special Cost Centers			69,533	69,533	530,939	600,472		600,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,764,341	591,420	6,892,172	13,248,333		13,248,333	(2,617,870)	10,630,463			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,364)	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				9
10	Interest and Other Investment Income	(38,355)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,027)	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	(54,144)	17		24
25	Fund Raising, Advertising and Promotional	(18,405)	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)	\$ (119,295)		\$	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)	(2,498,575)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,498,575)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,617,870)		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		530,939	10:3 43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 530,939	47

BHF USE ONLY							
48		49		50		51	52

ROLLING HILLS MANOR

ID# 0025239

Report Period Beginning: 11/01/2009

Ending: 10/31/2010

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:

11/01/2009

Ending:

10/31/2010

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	(2,027)	0	0	0	0	0	0	0	0	0	0	(2,027)	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	(873,179)	0	0	0	0	0	0	0	0	0	(873,179)	7
8	TOTAL General Services	(2,027)	(873,179)	0	(875,206)	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	(440,706)	0	0	0	0	0	0	0	0	0	(440,706)	15
16	TOTAL Health Care and Programs	0	(440,706)	0	(440,706)	16								
	C. General Administration													
17	Administrative	(54,144)	0	0	0	0	0	0	0	0	0	0	(54,144)	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	(18,405)	0	0	0	0	0	0	0	0	0	0	(18,405)	20
21	Clerical & General Office Expenses	0	(48,440)	0	0	0	0	0	0	0	0	0	(48,440)	21
22	Employee Benefits & Payroll Taxes	(6,364)	0	0	0	0	0	0	0	0	0	0	(6,364)	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	17,619	0	0	0	0	0	0	0	0	0	17,619	26
27	Other (specify):*	0	(650,893)	0	0	0	0	0	0	0	0	0	(650,893)	27
28	TOTAL General Administration	(78,913)	(681,714)	0	(760,627)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,940)	(1,995,599)	0	(2,076,539)	29								

STATE OF ILLINOIS

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2009 Ending:

Summary B

10/31/2010

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,355)	0	0	0	0	0	0	0	0	0	0	(38,355)	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	(502,976)	0	0	0	0	0	0	0	0	0	(502,976)	36
37	TOTAL Ownership	(38,355)	(502,976)	0	(541,331)	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)	(119,295)	(2,498,575)	0	0	0	0	0	0	0	0	0	(2,617,870)	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
Slovak American Charitable Association	100	N/A	N/A	N/A	N/A	N/A
N/A		N/A	N/A	Rolling Hills Place	Zion, Illinois	Assisted Living Facility

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Administrative Expenses	\$ 48,440	Slovak American Charitable Association		\$	\$ (48,440)	1
2	V	26 Liability Insurance	(17,619)	Slovak American Charitable Association			17,619	2
3	V	7 General Services	873,179	Rolling Hills Place			(873,179)	3
4	V	15 Healthcare and Programs	440,706	Rolling Hills Place			(440,706)	4
5	V	27 General Administration	650,893	Rolling Hills Place			(650,893)	5
6	V	36 Capital Expenses	502,976	Rolling Hills Place			(502,976)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,498,575			\$	\$ *	(2,498,575) 14

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

Facility Name & ID Number

ROLLING HILLS MANOR

#

0025239

Report Period Beginning:

11/01/2009

Ending:

10/31/2010

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	\$ 1,950	18:3	1
2	ANNE LESAK SCOTT	DIRECTOR	VICE PRESIDENT	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,950	18:3	2
3	JANET PILCH	DIRECTOR	TREASURER	NONE	NONE	1/2 HR.	2.00	DIR. FEE	2,100	18:3	3
4	DOROTHY MITCHELL	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,800	18:3	4
5	ELANOR PETRAS	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,500	18:3	5
6	MARION STEFO	DIRECTOR	MANG'T COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,800	18:3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,100		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:

11/01/2009

Ending: 0/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ NONE	\$ NONE		\$ NONE	25

Facility Name & ID Number

ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2009

Ending:

10/31/2010

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	L DFA REVENUE BONDS		REFINANCING OF SERIES			\$		\$											
2	SSERIES 2000	X	199 REVENUE BONDS	\$14,000.00	6/20/2000		2,600,000	2,154,512	6/29/2030	4.1700	\$ 111,940								
3																			
4																			
5																			
Working Capital																			
6																			
7																			
8																			
9	TOTAL Facility Related			\$14,000.00		\$ 2,600,000	\$ 2,154,512			\$ 111,940									
B. Non-Facility Related*																			
10																			
11																			
12																			
13																			
14	TOTAL Non-Facility Related					\$	\$			\$									
15	TOTALS (line 9+line14)					\$ 2,600,000	\$ 2,154,512			\$ 111,940									

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2009 report.		\$	NONE		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	NONE		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	NONE		3	
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	NONE		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	NONE		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	NONE		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	NONE		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2005	NONE	8	FOR BHF USE ONLY		
	2006	NONE	9			
	2007	NONE	10			
	2008	NONE	11			
	2009	NONE	12			
				13	FROM R. E. TAX STATEMENT FOR 2009 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROLLING HILLS MANOR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0025239

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2009 Ending:

10/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

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
69 BEDS / 61 UNITS
48000 SQUARE FEET

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: N/A
 3. 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:

	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>\$ 100,762</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	3 ACRES		\$ 100,762	3

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

Report Period Beginning:

11/01/2009

Ending:

10/31/2010**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	\$ 23,177	\$ 12,281	\$ 861,703	4
5		PREMIUM PAID UPON ACQUISITION	1979	1970	712,648	20,361	35	20,361		631,203	5
6		RENOVATIONS	1992	1992	1,234,270	30,857	40	30,857		570,851	6
7		RENOVATIONS	1992	1992	232,299		10			232,299	7
8		RENOVATIONS	1998	1998	695,702	17,393	40	17,393		209,480	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		SURFACING AND DRAINAGE		1984	37,141		10			37,141	13
14		SHRUBBERY		1985	1,061		10			1,061	14
15		RAMP		1985	38,992		20			38,992	15
16		MIXING VALVE		1985	325		20			325	16
17		FENCE		1986	1,257		20			1,257	17
18		RAMP		1986	5,400		20			5,400	18
19		ROOF		1986	33,997		20			33,997	19
20		HEATING UNITS		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		12,795	28
29		ROOF		1994	24,500		10			24,500	29
30		HEATING UNITS		1994	6,987		10			6,987	30
31		WATER LINE		1994	6,820	341	20	341		5,627	31
32		PARKING LOT SURFACING		1994	4,346	217	20	217		2,866	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.

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

11/01/2009 Ending: 10/31/2010

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	\$	10	\$	\$	\$ 14,321	37
38	RETAINING WALL	1996	38,975	1,949	20	1,949		28,258	38
39	OXYGEN ENVIRONMENT	1996	3,892		10			3,892	39
40	EMERGENCY GENERATOR	1996	10,089	673	15	673		9,755	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		10			5,500	44
45	SIGN	1999	2,768	69	40	69		829	45
46	SIGN	1999	4,668	117	40	117		1,402	46
47	PELLA WINDOWS	1999	7,855	393	20	393		4,518	47
48	CARPETING AND WALLPAPER	2000	9,279	464	15	464		7,657	48
49	SMOKE DETECTORS	2000	12,985	649	15	649		8,389	49
50	ROOF	2000	12,585	629	20	629		6,607	50
51	SEWER EXTENSION	2000	11,480	574	20	574		6,027	51
52	SHRUBBERY	2001	2,211	147	15	147		1,398	52
53	PAINT AND WALLPAPER	2001	1,510	151	10	151		1,435	53
54	VINYL FLOORING	2001	9,602	960	10	960		9,121	54
55	CARPETING AND WALLPAPER	2001	17,556	1,756	10	1,756		16,681	55
56	HAND RAILS	2001	11,425	571	20	571		5,425	56
57	PRESSURE VALVE	2001	4,636	232	20	232		2,203	57
58	EXHAUST FANS	2001	3,994	200	20	200		1,899	58
59	CARPETING AND TILE	2002	80,772	8,077	10	8,077		68,655	59
60	HAND RAILS	2002	28,365	1,418	40	1,418		12,054	60
61	CLASSROOM FLOORS ABD WALLS	2002	2,970	149	40	149		1,265	61
62	WOOD COLUMNS	2002	7,050	353	40	353		2,999	62
63	FLOOR OUTLETS	2002	4,606	230	40	230		1,956	63
64	DOOR	2002	7,360	368	40	368		3,128	64
65	VINYL FLOORING	2003	29,600	2,960	10	2,960		22,200	65
66	DOORS	2003	6,835	342	40	342		2,568	66
67	SIDEWALKS	2003	4,352	218	40	218		1,634	67
68	SHRUBBERY	2004	5,000	500	10	500		3,250	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,642,715	\$ 104,945		\$ 117,226	\$ 12,281	\$ 3,234,537	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:

11/01/2009 Ending: 10/31/2010

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	\$ 104,945		\$ 117,226	\$ 12,281	\$ 3,234,537	1
2	CARPETING	2004	27,900	2,790	10	2,790		18,135	2
3	DOORS	2004	11,800	590	20	590		3,835	3
4	DOORS	2005	3,372	169	20	169		927	4
5	WALL GUARDS AND RAILS	2005	3,540	354	10	354		1,947	5
6	VENTILATING DAMPERS	2005	3,538	236	15	236		1,298	6
7	DOOR PLATES AND LOCKS	2005	3,525	176	20	176		968	7
8	SIGNS	2005	3,662	366	10	366		2,013	8
9	SENSOR SECURITY SYSTEM	2005	24,322	1,216	20	1,216		6,688	9
10	TE;LEPHONECIRCUITRY	2005	5,483	366	15	366		2,011	10
11	FLOORING	2005	1,500	150	10	150		825	11
12	ALARM SYSTEM	2005	1,527	153	10	153		841	12
13	TE;LEPHONECIRCUITRY	2005	2,163	144	15	144		792	13
14	WATER LINES AND BOILER	2005	33,140	1,657	20	1,657		9,114	14
15	HVAC UNIT	2005	9,280	238	39	238		1,210	15
16	HVAC UNIT	2005	7,925	793	10	793		4,359	16
17	FLOORING	2006	7,148	715	10	715		3,933	17
18	ELECTRIC PANEL	2006	1,100	55	20	55		248	18
19	FREEZER CIRCUITRY	2006	1,986	132	15	132		594	19
20	ELEVATOR HYDRAULICS RENOVATIONS	2006	33,276	1,664	20	1,664		7,488	20
21	DOOR LOCKS	2006	1,830	92	20	92		414	21
22	CRASH RAILS	2006	578	29	20	29		130	22
23	BOILER PIPING	2006	1,742	87	20	87		392	23
24	SKYLIGHTS	2006	3,205	160	20	160		720	24
25	SIDEWALKS	2006	1,400	70	20	70		315	25
26	GENERATOR ELECTRIC SYSTEM	2006	1,336	134	10	134		603	26
27	PARKING LLOT SURFACING	2006	2,985	597	5	597		2,687	27
28	ELEVATOR LIGHTING	2006	1,527	76	20	76		329	28
29	WALK IN FREEZER	2006	33,813	1,691	20	1,691		7,609	29
30	SHRUBBERY	2006	4,512	451	10	451		1,860	30
31	100 WING - ELECTIRCAL	2006	18,869	943	20	943		4,244	31
32	100 WING - LIGHTING	2006	4,106	205	20	205		922	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,904,805	\$ 121,444		\$ 133,725	\$ 12,281	\$ 3,321,988	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:

11/01/2009 Ending: 10/31/2010

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 12B, Carried Forward		\$ 4,904,805	\$ 121,444		\$ 133,725	\$ 12,281	\$ 3,321,988	1
2	100 WING - CARPENTRY AND DOORS	2006	6,625	331	20	331		1,489	2
3	100 WING - FLOORING	2006	4,550	228	20	228		1,026	3
4	100 WING - PLUMBING	2006	1,742	88	20	88		396	4
5	100 WING - PAINTING AND WALLPAPER	2006	8,198	410	20	410		1,845	5
6	SEWERS	2007	31,553	1,578	20	1,578		5,523	6
7	PLUMBING CONNECTIONS	2007	3,384	169	20	169		592	7
8	SPRINKLER SYSTEM	2007	31,188	1,536	20	1,536		5,456	8
9	KITCHEN TILING	2007	1,420	142	10	142		497	9
10	THERMOSTATS	2007	3,585	358	10	358		1,253	10
11	DOORS AND LOCKS	2007	12,180	609	20	609		2,152	11
12	WINDOW TREATMENTS	2007	1,800	180	10	180		630	12
13	COLUMN CAPS	2007	7,534	462	20	462		1,617	13
14	ROOFING	2007	1,050	53	20	53		184	14
15	AUTOMATIC DOORS	2007	2,972	149	20	149		521	15
16	ELECTRICAL PANEL	2007	9,128	456	20	456		1,596	16
17	HAND RAILS	2007	3,200	160	20	160		560	17
18	100 WING - LIGHTING	2007	5,450	272	20	272		952	18
19	100 WING - DOORS	2007	3,885	194	20	194		679	19
20	100 WING - PAINTING AND WALLPAPER	2007	1,596	80	20	80		280	20
21	FIRE ALAARM SYSTEM	2008	15,772	789	20	789		1,972	21
22	AIR CONDITIONING UNIT	2008	1,700	170	10	170		425	22
23	WATER LINE	2008	14,210	474	30	474		1,185	23
24	CIRCUIT BREAKERS	2008	1,140	57	20	57		142	24
25	HEAT PUMB	2008	6,525	653	10	653		1,632	25
26	KITCHEN TILING	2008	1,018	51	20	51		127	26
27	SPRINKLER SYSTEM	2008	3,986	199	20	199		498	27
28	STORAGE FOOM DOORS	2008	12,170	609	20	609		1,522	28
29	CARPETING	2008	2,825	283	10	283		707	29
30	CARPETING	2008	2,580	258	10	258		645	30
31	WALL PANELS	2008	3,267	163	20	163		408	31
32	MAINTENANCE SINK	2008	965	48	20	48		120	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,112,003	\$ 132,653		\$ 144,934	\$ 12,281	\$ 3,358,619	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:

11/01/2009 Ending: 10/31/2010

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 12C, Carried Forward		\$ 5,112,003	\$ 132,653		\$ 144,934	\$ 12,281	\$ 3,358,619	1
2	SPRINKLER SYSTEM	2008	1,155	30	39	30		88	2
3	STORAGE ROOM DOORS	2008	3,958	101	39	101		301	3
4	DOOR LOCKS	2008	3,358	168	20	168		420	4
5	BOILER AND WATER TANKS	2008	11,920	596	20	596		1,488	5
6	RETAINING WALL	2008	46,418	2,321	20	2,321		5,732	6
7	DOORS AND LOCKS	2008	1,939	97	20	97		242	7
8	DRYER EXHAUST VENTS	2008	4,313	431	10	431		1,078	8
9	CARPETING	2008	3,600	360	10	360		900	9
10	LANDSCAPING AND SHRUBBERY	2008	18,783	939	20	939		2,348	10
11	ELEVATOR - ELECTRICAL	2009	58,435	1,498	39	1,498		2,247	11
12	WATER LINE PIPING	2009	15,146	388	39	388		582	12
13	FIRE ALARM SYSTEM	2009	15,302	392	39	392		621	13
14	SKYLIGHTS	2009	9,175	458	20	458		687	14
15	FLOORING	2009	2,092	209	10	209		314	15
16	FIRE ALARM SYSTEM	2009	5,273	135	39	135		203	16
17	NURSE CALL STATION SYSTEM	2009	5,186	132	39	132		198	17
18	TELEPHONE LINES	2009	3,810	381	10	381		572	18
19	LOBBY AND HALLWAY CARPETING & TILE	2009	37,322	2,488	15	2,488		3,724	19
20	LOBBY WINDOW TREATMENTS AND DOORS	2009	10,884	726	15	726		1,086	20
21	LOBBY AND HALLWAY WALL REFINISHING	2009	19,249	1,283	15	1,283		1,921	21
22	LOBBY CABINETRY AND PANELS	2009	23,229	1,549	15	1,549		2,318	22
23	FIRE ALARM SYSTEM	2009	758	19	39	19		29	23
24	DRIVEWAY TO ROUTE 173	2009	119,776	3,071	39	3,071		4,607	24
25	PARKING LOT PAVING	2009	8,499	567	15	567		850	25
26	PARKING LOT STRIPPING	2009	4,495	300	15	300		450	26
27	A/C COMPRESSOR	2009	3,348	334	10	334		501	27
28	PLUMBING AND HOT WATER TANK	2009	5,532	142	39	142		212	28
29	SUMP DRAIN	2010	1,200	30	20	30		30	29
30	FLOORING - BEAUTY SHOP	2010	4,182	209	10	209		209	30
31	FIXTURES - BEAUTY SHOP	2010	3,025	74	20	74		74	31
32	FIRE SYSTEM FAN	2010	13,477	173	39	173		173	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,576,842	\$ 152,254		\$ 164,535	12,281	\$ 3,392,824	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:

11/01/2009 Ending: 10/31/2010

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 12D, Carried Forward		\$ 5,576,842	\$ 152,254		\$ 164,535	\$ 12,281	\$ 3,392,824	1
2	SAFETY UNITS	2010	1,400	70	10	70		70	2
3	WATER MAIN	2010	19,875	255	39	255		255	3
4	LOBBY FLOORING	2010	1,737	87	10	87		87	4
5	STORM DRAIN	2010	4,072	52	39	52		52	5
6	KITCHEN CEILING	2010	25,291	843	15	843		843	6
7	FLOORING - DINING ROOM	2010	30,348	1,517	10	1,517		1,517	7
8	WOMENS' BATHROOM	2010	2,134	107	10	107		107	8
9	ROOFING A/C UNIT	2010	4,120	206	10	206		206	9
10	FLOORING - EAST ACTIVITY ROOM	2010	22,731	1,137	10	1,137		1,137	10
11	KITCHEN CABINETS	2010	754	38	10	38		38	11
12	TELEPHONE CABELING	2010	875	22	20	22		22	12
13	LANDSCAPING	2010	1,940	49	20	49		49	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,692,119	\$ 156,637		\$ 168,918	\$ 12,281	\$ 3,397,207	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	\$ 537,584	\$ 56,289	\$ 56,289	\$	3 to 15 YRS	\$ 315,445	71
72	Current Year Purchases	91,637	7,035	7,035		3 to 15 YRS	7,035	72
73	Fully Depreciated Assets	1,397,856	11,615	11,615		3 to 15 YRS	1,397,856	73
74								74
75	TOTALS	\$ 2,027,077	\$ 74,939	\$ 74,939	\$		\$ 1,720,336	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 EL DORADO	1995	\$ 40,018	\$	\$	\$	7 YRS	\$ 40,018	76
77	BUSINESS	2010 FORD VAN	2010	23,846	1,192	1,192		10 YRS	1,192	77
78										78
79										79
80	TOTALS			\$ 63,864	\$ 1,192	\$ 1,192	\$		\$ 41,210	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)	\$ 7,883,822	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 232,768	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 245,049	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,281	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,158,753	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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		hrs	\$ 615,415		\$			\$ 615,415	1
2	Licensed Speech and Language Development Therapist		hrs	77,590					77,590	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs	694,719					694,719	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 1,387,724		\$	\$		\$ 1,387,724	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: **11/01/2009**

Ending:

10/31/2010**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **10/31/2010**

(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	\$ 406,004	\$ 797,192	1
2	Cash-Patient Deposits	10,164	10,164	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u>)	1,361,509	1,394,851	3
4	Supply Inventory (priced at)	208,182	258,714	4
5	Short-Term Investments			5
6	Prepaid Insurance	39,471	41,625	6
7	Other Prepaid Expenses	86,564	95,914	7
8	Accounts Receivable (owners or related parties)	52,014		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,163,908	\$ 2,598,460	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,674,940	12
13	Land	100,763	236,453	13
14	Buildings, at Historical Cost	5,692,119	12,473,919	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,090,940	2,914,672	16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges	(5,158,753)	(7,224,168)	18
19	Organization & Pre-Operating Costs	168,793	446,032	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (A/R Settlement Claim)	117,381		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,011,243	\$ 10,521,848	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,175,151	\$ 13,120,308	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 566,221	\$ 596,149	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,164	10,164	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	486,197	514,771	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,239	19,677	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Resident and other credits</u>	75,430	269,155	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,144,251	\$ 1,409,916	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,154,512	6,795,000	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)	\$ 2,154,512	\$ 6,795,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,298,763	\$ 8,204,916	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,876,388	\$ 4,915,392	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,175,151	\$ 13,120,308	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,337,498	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,337,498	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	577,894	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)	\$ 577,894	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)	\$ 4,915,392	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**Report Period Beginning: **11/01/2009**Ending: **10/31/2010**

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	\$ 11,045,346	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,045,346	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,474,102	6
7	Oxygen	77,740	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,551,842	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	6,364	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,364	23
D. Non-Operating Revenue			
24	Contributions	3,945	24
25	Interest and Other Investment Income***	38,355	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,300	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Realized gain on investments	43,249	28
28a	Unrealized gain of investments	137,126	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 180,375	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,826,227	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,496,051	31
32	Health Care	6,987,318	32
33	General Administration	2,836,026	33
B. Capital Expense			
34	Ownership	859,405	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	69,533	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,248,333	40
41	Income before Income Taxes (line 30 minus line 40)**	577,894	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 577,894	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:

11/01/2009

Ending:

10/31/2010

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	1,720	2,118	\$ 80,082	\$ 37.81	1
2	Assistant Director of Nursing	1,783	2,047	67,204	32.83	2
3	Registered Nurses	39,660	43,333	1,372,738	31.68	3
4	Licensed Practical Nurses	16,579	18,513	491,625	26.56	4
5	CNAs & Orderlies	136,949	147,872	1,857,347	12.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,149	5,926	90,330	15.24	8
9	Activity Director	1,896	2,120	45,717	21.56	9
10	Activity Assistants	5,720	6,214	64,365	10.36	10
11	Social Service Workers	3,396	3,665	76,389	20.84	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,240	57,039	25.46	13
14	Head Cook	4,049	4,391	99,335	22.62	14
15	Cook Helpers/Assistants	17,539	19,528	166,753	8.54	15
16	Dishwashers					16
17	Maintenance Workers	13,121	14,869	160,479	10.79	17
18	Housekeepers	24,142	26,849	252,340	9.40	18
19	Laundry	16,555	18,376	171,571	9.34	19
20	Administrator	1,872	2,296	96,831	42.17	20
21	Assistant Administrator					21
22	Other Administrative	9,726	10,699	168,115	15.71	22
23	Office Manager	1,944	2,160	63,342	29.33	23
24	Clerical	8,271	9,172	180,279	19.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,056	2,296	70,832	30.85	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,268	2,456	30,789	12.54	31
32	Other Health Care(specify)					32
33	Other(specify) Executive Director	1,824	2,080	100,839	48.48	33
34	TOTAL (lines 1 - 33)	318,187	349,220	\$ 5,764,341 *	\$ 16.51	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	1,575	\$ 39,379	1:3	35
36	Medical Director	240	18,000	3:3	36
37	Medical Records Consultant	62	1,536	10a:3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	4	184	10a:3	40
41	Occupational Therapy Consultant	59	2,951	10a:3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	819	11:3	44
45	Social Service Consultant	302	10,564	12:3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,275	\$ 73,433		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	Adminstrator	None	\$ 90,423	Workers' Compensation Insurance	\$ 112,817	IDPH License Fee	\$	
Miron Tabic	Adminstrator	None	6,408	Unemployment Compensation Insurance	33,937	Advertising: Employee Recruitment	17,619	
James S. Stefo, Sr.	Executive Director	None	100,840	FICA Taxes	423,531	Health Care Worker Background Check		
				Employee Health Insurance	337,648	(Indicate # of checks performed _____)		
				Employee Meals	22,976	Patient Background Checks	5,040	
				Illinois Municipal Retirement Fund (IMRF)*		Inspections and Fees	4,606	
				Employee Life and Disability Insurance	48,431	Advertising	26,935	
				PTO Expense	9,437	Life Service Network	4,302	
				Employee Meal Reimbursement	(6,364)	AAHSA	3,420	
				Employee Retirement Funding	51,575	Memberships	1,048	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(18,405)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 197,671	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,033,988	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 44,565	
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			\$ 54,144			\$	Out-of-State Travel	\$
							In-State Travel	
							Automotive Expense	1,534
							Ttravel Reimbursement	3,863
							Seminar Expense	5,849
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 54,144	TOTAL		\$ NONE	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 11,246
C. Professional Services								
Vendor/Payee	Type		Amount					
McGladrey & Pullen	General Audit		\$ 37,496					
Frost & Ruttneberg	401K Audit		6,000					
James S. Stefo & Co.	Accounting		7,020					
Polsinelli Shughart	Legal		58,290					
Smith Amundsen	Legal		6,095					
Wessels Sherman	Legal		75					
Mages & Price	Legal		399					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 115,375					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ROLLING HILLS MANOR# 0025239Report Period Beginning: 11/01/2009Ending: 10/31/2010**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 \$4,302 AAHSA \$3,420
- (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. \$ 69,377 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 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. \$ 69,533
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. \$ 22,976 Has any meal income been offset against related costs? YES Indicate the amount. \$ 7,043
- (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?
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? NO
Firm Name: FROST AND RUTTENBERG
- (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

\$22,796 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

\$530,939 OF PRESCRIPTION DRUG COSTS HAVE BEEN DEDUCTED FROM LINE 10 (NURSING COSTS) AND HAVE BEEN ADDED TO LINE 43 (SPECIAL COST CENTERS).