



Facility Name & ID Number Elmwood Terrace Healthcare Center

# 0046128 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	68	Skilled (SNF)	68	24,888	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	68	TOTALS	68	24,888	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,780	56	3,357	5,193	8
9	SNF/PED					9
10	ICF	16,017	508		16,525	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,797	564	3,357	21,718	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.26%

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 02/18/03

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

YES  Date 02/18/03 NO

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

YES  NO  If YES, enter number of beds certified 68 and days of care provided 3,357

Medicare Intermediary Riverbend

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

**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	138,645	12,000	4,525	155,170		155,170	155,170			1
2	Food Purchase		151,256		151,256	(3,000)	148,256	148,256			2
3	Housekeeping	162,099	34,244	31,732	228,075		228,075	228,075			3
4	Laundry		2,403		2,403		2,403	2,403			4
5	Heat and Other Utilities			64,706	64,706		64,706	64,706			5
6	Maintenance	44,921		108,020	152,941		152,941	152,941			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	345,665	199,903	208,983	754,551	(3,000)	751,551	751,551			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			41,000	41,000		41,000	41,000			9
10	Nursing and Medical Records	1,160,004	122,611	18,000	1,300,615		1,300,615	1,300,615			10
10a	Therapy										10a
11	Activities	38,297	3,216		41,513		41,513	41,513			11
12	Social Services	41,760		1,239	42,999		42,999	42,999			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,240,061	125,827	60,239	1,426,127		1,426,127	1,426,127			16
	<b>C. General Administration</b>										
17	Administrative	94,235		42,000	136,235		136,235	136,235			17
18	Directors Fees										18
19	Professional Services			53,627	53,627		53,627	(17,072)	36,555		19
20	Dues, Fees, Subscriptions & Promotions			9,548	9,548		9,548	(5,516)	4,032		20
21	Clerical & General Office Expenses	59,866	46,471	48,787	155,124		155,124	(2,376)	152,748		21
22	Employee Benefits & Payroll Taxes			305,718	305,718	3,000	308,718		308,718		22
23	Inservice Training & Education										23
24	Travel and Seminar			22,710	22,710		22,710		22,710		24
25	Other Admin. Staff Transportation			8,373	8,373		8,373		8,373		25
26	Insurance-Prop.Liab.Malpractice			65,063	65,063		65,063		65,063		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	154,101	46,471	555,826	756,398	3,000	759,398	(24,964)	734,434		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,739,827	372,201	825,048	2,937,076		2,937,076	(24,964)	2,912,112		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.

Facility Name & ID Number Elmwood Terrace Healthcare Center

#0046128

Report Period Beginning:

01/01/12

Ending:

12/31/12

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			64,386	64,386	64,386	2,863	67,249				30
31	Amortization of Pre-Op. & Org.						13,134	13,134				31
32	Interest			62,212	62,212	62,212	86,506	148,718				32
33	Real Estate Taxes						51,990	51,990				33
34	Rent-Facility & Grounds			130,000	130,000	130,000	(130,000)					34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			256,598	256,598	256,598	24,493	281,091				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			145,360	145,360	145,360		145,360				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			145,360	145,360	145,360		145,360				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,739,827	372,201	1,227,006	3,339,034	3,339,034	(471)	3,338,563				45

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

Facility Name & ID Number Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning: 01/01/12

Ending: 12/31/12

**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				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	(8,046)	30		9
10	Interest and Other Investment Income	(116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,072)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,516)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,011)	21		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>	\$ (33,191)		\$	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)	32,720		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 32,720		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (471)		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					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>						
48		49		50		51
						52

Elmwood Terrace Healthcare Center

ID# 0046128

Report Period Beginning: 01/01/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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 Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Operating Expenses	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>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</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>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	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,072)	0	0	0	0	0	0	0	0	0	0	(17,072)	19
20	Fees, Subscriptions & Promotions	(5,516)	0	0	0	0	0	0	0	0	0	0	(5,516)	20
21	Clerical & General Office Expenses	(2,441)	65	0	0	0	0	0	0	0	0	0	(2,376)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(25,029)</b>	<b>65</b>	<b>0</b>	<b>(24,964)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(25,029)</b>	<b>65</b>	<b>0</b>	<b>(24,964)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning:

01/01/12 Ending:

12/31/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(8,046)	10,909	0	0	0	0	0	0	0	0	0	2,863	30
31	Amortization of Pre-Op. & Org.	0	13,134	0	0	0	0	0	0	0	0	0	13,134	31
32	Interest	(116)	86,622	0	0	0	0	0	0	0	0	0	86,506	32
33	Real Estate Taxes	0	51,990	0	0	0	0	0	0	0	0	0	51,990	33
34	Rent-Facility & Grounds	0	(130,000)	0	0	0	0	0	0	0	0	0	(130,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(8,162)</b>	<b>32,655</b>	<b>0</b>	<b>24,493</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>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(33,191)</b>	<b>32,720</b>	<b>0</b>	<b>(471)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Ari Haas</u>	<u>40</u>			<u>Elmwood LLC</u>	<u>Aurora</u>	<u>Bldg Rental</u>
<u>David Abell</u>	<u>30</u>					
<u>Joseph Brandman</u>	<u>30</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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>34 Rent</u>	\$ <u>130,000</u>	<u>Elmwood Terrace, LLC</u>	<u>100.00%</u>	\$	<u>(130,000)</u>	1
2	V	<u>32 Interest</u>				<u>86,622</u>	<u>86,622</u>	2
3	V	<u>33 Real Estate Tax</u>				<u>51,990</u>	<u>51,990</u>	3
4	V	<u>30 Depreciation</u>				<u>10,909</u>	<u>10,909</u>	4
5	V	<u>31 Amortization</u>				<u>13,134</u>	<u>13,134</u>	5
6	V	<u>21 Office</u>				<u>65</u>	<u>65</u>	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ <b>130,000</b>			\$ <b>162,720</b>	\$ * <b>32,720</b>	14

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

Facility Name & ID Number

Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning:

01/01/12

Ending:

12/31/12

VII. RELATED PARTIES

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/12 Ending: 12/31/12

## 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	David Abell		Management	30.00		20	50.00	Management	\$ 21,000	17-3	1
2	Joseph Brandman		Management	30.00		20	50.00	Management	21,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,000		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 Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning:

01/01/12

Ending: 12/31/12

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	First Equity Bank		X	Mortgage	\$7,968.51	3/15/04	\$ 1,200,000	\$		8.2500	\$ 37,590	1				
2	MB Financial		X	Mortgage	\$22,000.00	09/06/12	8,150,000	8,150,000	09/05/14	4.2500	49,031	2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6	MB Financial		X	Working Capital		11/20/08	450,000	890,000	06/05/13	4.2500	52,868	6				
7	Marvin Wolfe		X	Working Capital		06/01/12	400,000			6.5000	9,345	7				
8												8				
9	<b>TOTAL Facility Related</b>				\$29,968.51		\$ 10,200,000	\$ 9,040,000			\$ 148,834	9				
<b>B. Non-Facility Related*</b>																
10	Interest Income										(116)	10				
11												11				
12												12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(116)	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 10,200,000	\$ 9,040,000			\$ 148,718	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2011 report.		\$	<u>38,320</u>		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.)		\$	<u>44,708</u>		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>6,388</u>		3										
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>45,602</u>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>51,990</u>		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2007	<u>31,177</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$ _____ 13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____ 14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____ 15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____ 13	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14	15	LESS REFUND FROM LINE 6 \$ _____ 15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____ 13														
14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14														
15	LESS REFUND FROM LINE 6 \$ _____ 15														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16														
	2008	<u>31,438</u>	9												
	2009	<u>34,900</u>	10												
	2010	<u>34,651</u>	11												
	2011	<u>37,596</u>	12												
<u>44708 x 1.02</u>															

**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.**

## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Terrace Healthcare Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0046128

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 FAX #: 773-338-4414

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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.	<u>15-20-276-013</u>	<u></u>	\$ <u>4,795.00</u>	\$ <u></u>
2.	<u>15-20-276-014</u>	<u></u>	\$ <u>39,913.00</u>	\$ <u>39,913.00</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u><u>44,708.00</u></u>	\$ <u><u>39,913.00</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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 Elmwood Terrace Healthcare Center

# 0046128 Report Period Beginning:

01/01/12 Ending:

12/31/12

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 15,481 B. General Construction Type: Exterior Brick Frame Brick 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).

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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: 26,572 66,085 2. Number of Years Over Which it is Being Amortized: 15  
 3. Current Period Amortization: 13,134 4. Dates Incurred: 03/04 06/12

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>14,166</u>	<u>2003</u>	<u>\$ 50,000</u>	1
2					2
3	<b>TOTALS</b>	<b>14,166</b>		<b>\$ 50,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	68	2003		\$ 300,000	\$ 10,909	27.5	\$ 10,909	\$	\$ 107,726	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Paving		2005	11,969	435	27.5	435		3,208	9
10	Tiling		2005	3,895	142	27.5	142		1,083	10
11	Alarms		2005	9,818	357	27.5	357		2,782	11
12	Corridor Renovation		2010							12
13	New Floor			37,224		27.5	1,354	1,354	4,062	13
14	Wallcovering			8,400		27.5	305	305	915	14
15	Hand Rails, Bumper Guards, and Corner Guards			21,479		27.5	781	781	2,343	15
16	Installation of Door Casings			10,125		27.5	368	368	1,104	16
17	Light Fixtures			9,880		27.5	359	359	1,077	17
18	Custom Signage			3,661		27.5	133	133	399	18
19	Resident Rooms Renovation		2010							19
20	Remove Existing Cove Base and Install New Cove Base			38,334		27.5	1,394	1,394	4,182	20
21	Room Renovation			32,671		27.5	1,188	1,188	3,564	21
22	Bumper Guards			6,984		27.5	254	254	762	22
23	Cubicle Curtains			14,852		27.5	540	540	1,620	23
24	Head and Foot Boards			7,300		27.5	265	265	795	24
25	Window Treatments			10,531		27.5	383	383	1,149	25
26	Wall Scones			5,321		27.5	193	193	579	26
27	Light Fixtures			17,953		27.5	653	653	1,959	27
28	Bathroom Renovation		2010							28
29	New Floor			10,185		27.5	370	370	1,110	29
30	Mirrirs			2,657		27.5	97	97	291	30
31	Lighting			3,408		27.5	124	124	372	31
32	Nurses Station Renovation			10,348		27.5	376	376	1,128	32
33	Dining Room Renovation		2010							33
34	New floor			8,103		27.5	295	295	885	34
35	Wallcovering			2,053		27.5	75	75	225	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 Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning:

01/01/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Living Room Renovation	2010	\$	\$		\$	\$	\$	37
38	New Carpeting		1,859		27.5	68	68	204	38
39	Wallcovering		1,524		27.5	55	55	165	39
40	Window Treatments		699		27.5	25	25	75	40
41	Renovating Beauty Salon	2010							41
42	New floor		1,812		27.5	66	66	198	42
43	Wallcovering		1,415		27.5	51	51	153	43
44	Custom Cabinets		8,125		27.5	295	295	885	44
45	Lighting		1,354		27.5	49	49	147	45
46	Shampoo Station		1,950		27.5	71	71	213	46
47	Corridors, Business Office, Small Dining Room	2010							47
48	Main Dining Room, DON Office, Lounge								48
49	Painting and Wallcoverings		69,500		27.5	2,527	2,527	7,581	49
50	Install New Windows	2010	32,000		27.5	1,164	1,164	3,492	50
51	Install Dining Room Window Treatments	2010	743		27.5	27	27	81	51
52	Repaving Parking Lot	2010	39,550		27.5	1,438	1,438	4,314	52
53	Enlarge Therapy Room and Install New Flooring, Plumbing	2012							53
54	, Lighting, and Electrical, Install New Sliding Doors		356,721	17,836	15	11,891	(5,945)	11,891	54
55	Replace all Doors and Install new lighting in resident rooms								55
56	New Nurses Station and Medication Room								56
57	New Bathroom in dialysis room, Build 2 new showers								57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,104,403	\$ 29,679		\$ 39,077	\$ 9,398	\$ 172,719	70

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

Facility Name & ID Number Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 236,725	\$ 616	\$ 23,672	\$ 23,056	10	\$ 156,368	71
72	Current Year Purchases	45,000	45,000	4,500	(40,500)	10	4,500	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 281,725	\$ 45,616	\$ 28,172	\$ (17,444)		\$ 160,868	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,436,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,295	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,249	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,046)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 333,587	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

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. \_\_\_\_\_ /2013                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

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		\$	\$	21

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/12 Ending: 12/31/12  
**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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	\$		\$										1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescrpts													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>			\$		\$		\$			\$			\$		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 Elmwood Terrace Healthcare Center# 0046128Report Period Beginning: 01/01/12

Ending:

12/31/12

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (98,879)	\$ 3,561,581	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,855,156	2,855,156	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,279	75,279	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From Others</u>	328,188	1,080,631	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,159,744	\$ 7,572,647	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost	236,700	536,700	14
15	Leasehold Improvements, at Historical Cost	953,217	953,217	15
16	Equipment, at Historical Cost	181,725	281,725	16
17	Accumulated Depreciation (book methods)	(737,343)	(945,069)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	159,399	252,056	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(117,399)	(144,338)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 676,299	\$ 984,291	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,836,043	\$ 8,556,938	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 310,382	\$ 310,382	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	890,000	890,000	29
30	Accrued Salaries Payable	15,207	15,207	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,949	10,949	31
32	Accrued Real Estate Taxes(Sch.IX-B)		45,602	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,406	14,406	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Others</u>	109,272	109,272	36
37	<u>Due to LLC</u>	967,545		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,317,761	\$ 1,395,818	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		8,150,000	39
40	Mortgage Payable			40
41	Bonds Payable			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>	\$	\$ 8,150,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,317,761	\$ 9,545,818	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,518,282	\$ (988,880)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,836,043	\$ 8,556,938	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 802,946	1
2	Restatements (describe):		2
3	Additional income from 2011 rate change	237,103	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,040,049	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	849,233	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	(371,000)	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)	\$ 478,233	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,518,282	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,188,151	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,188,151	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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		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>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	116	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 116	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,188,267	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	754,551	31
32	Health Care	1,426,127	32
33	General Administration	756,398	33
<b>B. Capital Expense</b>			
34	Ownership	256,598	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	145,360	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,339,034	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	849,233	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 849,233	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,787,544	44
45	Private Pay - Net Inpatient Revenue	101,520	45
46	Medicare - Net Inpatient Revenue	1,299,087	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,188,151	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? **no,cash basis** If not, please attach a reconciliation.

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center

# 0046128

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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	1,784	1,992	\$ 74,435	\$ 37.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,852	9,318	273,117	29.31	3
4	Licensed Practical Nurses	11,365	12,408	341,589	27.53	4
5	CNAs & Orderlies			470,863		5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	395	551	7,289	13.23	9
10	Activity Assistants	3,589	3,685	31,008	8.41	10
11	Social Service Workers	1,956	2,088	41,760	20.00	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,104	37,878	18.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,389	10,064	100,767	10.01	15
16	Dishwashers					16
17	Maintenance Workers	2,901	3,052	44,921	14.72	17
18	Housekeepers	12,586	13,671	162,099	11.86	18
19	Laundry					19
20	Administrator	2,024	2,206	94,235	42.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,789	6,025	59,866	9.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	62,582	67,164	\$ 1,739,827 *	\$ 25.90	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	96	\$ 4,525	1-3	35
36	Medical Director	586	41,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	275	18,000	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	30	1,239	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	987	\$ 64,764		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)		\$		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		
Catherine Wood	Administrator		\$ 94,235	Workers' Compensation Insurance	\$ 64,358	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	76,058	Advertising: Employee Recruitment			
				FICA Taxes	133,097	Health Care Worker Background Check			
				Employee Health Insurance	32,205	(Indicate # of checks performed)			
				Employee Meals	3,000	Patient Background Checks	30 300		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	5,516		
						Chicago Sun Times	1,742		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,235						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 308,718	Less: Public Relations Expense	( )		
Management fee- David Abell			\$ 21,000			Non-allowable advertising	(5,516)		
Management Fee- Jospeh Brandman			21,000			Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 42,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$	
Mendel Schneider	Accounting		\$ 10,950						
Richard Peelo	Accounting		6,200						
Frost Ruttenberg	Public Aid Consulting		5,697						
Mcvey & Parsky	Legal		9,176				In-State Travel		
Stephen Sher	Legal Adj Out		2,045						
Meyer Magence	Legal		2,207						
Much Shelist	Legal		170						
National Datacare	Trust Fees		1,250				Seminar Expense		
Much Shelist	Legal adj- Out		15,027				Coms Interactive	21,577	
Personnel Planners	UC Tax Consultant		905				Embrace	1,133	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 53,627	TOTAL			\$	Entertainment Expense	( )
								(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 22,710	

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128

Report Period Beginning:

01/01/12

Ending:

12/31/12**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? No  
If YES, give association name and amount. \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,500 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 145,360  
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. \$ 3,000 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No  
**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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (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.