

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

<p>I. IDPH License ID Number: <u>0003038</u></p> <p>Facility Name: <u>Elmhurst Extended Care Ctr</u></p> <p>Address: <u>200 East Lake Street</u> <u>Elmhurst</u> <u>60126</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 516-5000</u> Fax # <u>(630) 834-0480</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/18/1961</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Andrew B. Cutler</u> Telephone Number: <u>(847) 940-3269</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2013</u> to <u>12/31/2013</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 940-3269</u> Fax : <u>(847) 964-5469</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 940-3269</u> Fax : <u>(847) 964-5469</u>
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Facility Name & ID Number Elmhurst Extended Care Ctr

0003038 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 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	3,397	15,962	5,806	25,165	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,397	15,962	5,806	25,165	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.84%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 08/09/1960

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 5,284

Medicare Intermediary National Government Services

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.

Facility Name & ID Number Elmhurst Extended Care Ctr # 0003038 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	276,431	39,895		316,326		316,326	(13,532)	302,794		1
2	Food Purchase		181,932		181,932		181,932		181,932		2
3	Housekeeping		38,503		38,503		38,503		38,503		3
4	Laundry	29,224	13,105	1,128	43,457		43,457		43,457		4
5	Heat and Other Utilities			113,833	113,833		113,833		113,833		5
6	Maintenance	210,509		96,547	307,056		307,056		307,056		6
7	Other (specify):*										7
8	TOTAL General Services	516,164	273,435	211,508	1,001,107		1,001,107	(13,532)	987,575		8
	B. Health Care and Programs										
9	Medical Director			38,970	38,970		38,970		38,970		9
10	Nursing and Medical Records	2,101,029	87,867	245,308	2,434,204		2,434,204	(23,856)	2,410,348		10
10a	Therapy		6,017	2,228	8,245		8,245		8,245		10a
11	Activities	113,293	476	2,192	115,961		115,961		115,961		11
12	Social Services	67,269			67,269		67,269		67,269		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,281,591	94,360	288,698	2,664,649		2,664,649	(23,856)	2,640,793		16
	C. General Administration										
17	Administrative	115,319			115,319		115,319		115,319		17
18	Directors Fees										18
19	Professional Services			59,833	59,833		59,833	(15,888)	43,945		19
20	Dues, Fees, Subscriptions & Promotions			38,372	38,372		38,372	(30,498)	7,874		20
21	Clerical & General Office Expenses	340,108	11,069	1,271,096	1,622,273		1,622,273	(14,243)	1,608,030		21
22	Employee Benefits & Payroll Taxes			533,509	533,509		533,509	(4,702)	528,807		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,141	18,141		18,141		18,141		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			74,061	74,061		74,061		74,061		26
27	Other (specify):*										27
28	TOTAL General Administration	455,427	11,069	1,995,012	2,461,508		2,461,508	(65,331)	2,396,177		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,253,182	378,864	2,495,218	6,127,264		6,127,264	(102,719)	6,024,545		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			200,899	200,899		200,899	59,927	260,826		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			5,718	5,718		5,718		5,718		33
34	Rent-Facility & Grounds			1,597	1,597		1,597		1,597		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			208,214	208,214		208,214	59,927	268,141		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	366,212	247,948	94,342	708,502		708,502		708,502		39
40	Barber and Beauty Shops			13,722	13,722		13,722	(13,722)			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee				170,023		170,023		170,023		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	366,212	247,948	108,064	892,247		892,247	(13,722)	878,525		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,619,394	626,812	2,811,496	7,227,725		7,227,725	(56,514)	7,171,211		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	(13,532)	01		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	59,927	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,583)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(375)	21		18
19	Entertainment				19
20	Contributions	(4,700)	21		20
21	Owner or Key-Man Insurance	(4,702)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(262)	21		24
25	Fund Raising, Advertising and Promotional	(8,245)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(22,253)	20		28
29	Other-Attach Schedule	(54,789)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,514)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (56,514)		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					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Elmhurst Extended Care Ctr

ID# 0003038

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Comfort Items	\$ (23,856)	10	1
2	Bank Charges	(230)	21	2
3	Barber & Beauty Expense	(13,722)	40	3
4	Misc. Income	(1,093)	21	4
5	Non-Allowable Legal	(15,888)	19	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	(54,789)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmhurst Extended Care Ctr# 0003038

Report Period Beginning:

01/01/2013

Ending:

12/31/2013**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)	
1	A. General Services													
1	Dietary	(13,532)	0	0	0	0	0	0	0	0	0	0	(13,532)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,532)	0	0	0	0	0	0	0	0	0	0	(13,532)	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	(23,856)	0	0	0	0	0	0	0	0	0	0	(23,856)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(23,856)	0	0	0	0	0	0	0	0	0	0	(23,856)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,888)	0	0	0	0	0	0	0	0	0	0	(15,888)	19
20	Fees, Subscriptions & Promotions	(30,498)	0	0	0	0	0	0	0	0	0	0	(30,498)	20
21	Clerical & General Office Expenses	(14,243)	0	0	0	0	0	0	0	0	0	0	(14,243)	21
22	Employee Benefits & Payroll Taxes	(4,702)	0	0	0	0	0	0	0	0	0	0	(4,702)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(65,331)	0	0	0	0	0	0	0	0	0	0	(65,331)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(102,719)	0	0	0	0	0	0	0	0	0	0	(102,719)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmhurst Extended Care Ctr# 0003038

Report Period Beginning:

01/01/2013 Ending:12/31/2013

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	59,927	0	0	0	0	0	0	0	0	0	0	59,927	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	59,927	0	59,927	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	(13,722)	0	0	0	0	0	0	0	0	0	0	(13,722)	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	(13,722)	0	(13,722)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(56,514)	0	(56,514)	45									

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
John Massard	100			N/A		

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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
1	V		\$				\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$				\$	\$ *	14

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Elmhurst Extended Care Ctr

#

0003038

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	John Massard	Owner	Administrator	100.00	None	40	100.00	Salary	\$ 115,319	17-01	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 115,319		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Elmhurst Extended Care Ctr

0003038 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Elmhurst Extended Care Ctr

0003038

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	N/A																			
2																				
3																				
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related																			
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)																			

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

		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 2012 report.				\$	44,051	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	49,769	2
3. Under or (over) accrual (line 2 minus line 1).				\$	5,718	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)				\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	5,718	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	39,167	8			
	2009	40,689	9			
	2010	43,259	10			
	2011	44,051	11			
	2012	49,769	12			
Due to the sale of the facility there were no accrued real estate taxes at year end as they were relieved through the closing of the sale.						
				FOR BHF USE ONLY		
				13	FROM R. E. TAX STATEMENT FOR 2012	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmhurst Extended Care Ctr COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0003038

CONTACT PERSON REGARDING THIS REPORT Andrew Cutler

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-36-309-029</u>	<u>Long-Term Care Property</u>	\$ <u>49,768.52</u>	\$ <u>49,768.52</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>49,768.52</u></u>	\$ <u><u>49,768.52</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Rows include Resident Care, Parking Lot, and TOTALS.

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		
Bed*s	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1961	1961	\$ 122,779	\$	40	\$	\$	\$ 122,779	4
5		1976	1976	1,174,346		40	29,359	29,359	1,133,938	5
6		1980	1980	46,390		40	1,160	1,160	39,432	6
7		1998	1998	700		40	18	18	280	7
8		1998	1998	43,075		40	1,077	1,077	16,243	8
Improvement Type**										
9	Various		1983	7,336		20			7,336	9
10	Various		1984	5,800		20			5,800	10
11	Various		1987	1,630		20			1,630	11
12	Various		1989	7,744		20			7,744	12
13	Various		1995	4,900		20	245	245	4,553	13
14	Various		1996	4,960		20	248	248	4,381	14
15	Various		1998	6,800		20	340	340	5,440	15
16	Various		1999	12,875		20	644	644	9,656	16
17	Various		2001	4,340		20	217	217	2,821	17
18	Various		2002	20,290		20	1,015	1,015	12,174	18
19	Various		2003	1,980		20	99	99	1,089	19
20	Various		2004	156,262		20	7,813	7,813	78,131	20
21	Various		2005	141,628		20	7,081	7,081	63,733	21
22	Various		2006	86,017		20	4,301	4,301	33,307	22
23	Various		2007	78,095		20	3,905	3,905	27,333	23
24	Various		2008	135,277		20	6,764	6,764	40,583	24
25	Various		2009	251,765		20	12,588	12,588	62,645	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	Book Depreciation				140,972					36

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

See Page 12A, Line 70 for total

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

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	Streamline Painting	2010	\$ 17,289	\$	20	\$ 864	\$ 864	\$ 3,458	37
38	Replace Basement Hallway Floor	2011	14,396		20	720	720	2,159	38
39	Replace Basement Office Floor	2011	14,289		20	714	714	2,143	39
40	Add Rooftop Deck	2011	81,115		20	4,056	4,056	12,167	40
41	Replace West Wing Floor	2011	26,573		20	1,329	1,329	3,986	41
42	East Rooms and Landing Profile Flooring	2012	50,713		20	2,536	2,536	4,015	42
43	Front Office Profile Flooring	2012	3,772		20	189	189	267	43
44	Front Office Counter Tops	2012	2,170		20	109	109	154	44
45	Storage Room and Back Hallway Flooring	2012	4,785		20	239	239	339	45
46	Cabinets on 1 East and 2 East Nursing Stations	2013	21,000		20	788	788	788	46
47	Lighting LED Conversions, Hallways, Nursing Stations, Entire Fac	2013	11,865		20	148	148	148	47
48	1East Flooring	2013	11,560		20	48	48	48	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,574,516	\$ 140,972		\$ 88,612	\$ 88,612	\$ 1,710,700	70

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

Facility Name & ID Number Elmhurst Extended Care Ctr

0003038

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	\$ 1,592,577	\$	\$ 84,844	\$ 84,844	10	\$ 1,086,489	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,592,577	\$	\$ 84,844	\$ 84,844		\$ 1,086,489	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		2007 Lexus	2006	\$ 28,823	\$	\$	\$	5	\$ 28,823	76
77		Auto	2006	12,868		1,226	1,226	5	12,868	77
78		2010 Ford	2010	69,207		12,377	12,377	5	50,752	78
79		2012 GMC Yukon	2010	61,885		13,841	13,841	5	55,346	79
80	TOTALS			\$ 172,783	\$	\$ 27,444	\$ 27,444		\$ 147,789	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,438,842	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,972	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,900	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,928	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,944,978	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.

Facility Name & ID Number Elmhurst Extended Care Ctr

0003038

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Office Storage Rental				1,597			5
6								6
7	TOTAL				\$ 1,597			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.	_____ /2014	\$ _____
13.	_____ /2015	\$ _____
14.	_____ /2016	\$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	39-01, 39-03	hrs	\$ 103,686		\$ 47,254	\$		\$ 150,940	1
2	Licensed Speech and Language Development Therapist	39-01, 39-03	hrs			12,480			12,480	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01, 39-03	hrs	262,526		14,503			277,029	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				247,948		247,948	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab & X Ray</u>	39-03					20,105		20,105	12
13	Other (specify):									13
14	TOTAL			\$ 366,212		\$ 74,237	\$ 268,053		\$ 708,502	14

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

Facility Name & ID Number Elmhurst Extended Care Ctr

0003038

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,537,977	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (138,952))	363,367		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,639		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>AR Employee Loan</u>	800		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,929,783	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,000,000		11
12	Long-Term Investments			12
13	Land	98,966		13
14	Buildings, at Historical Cost	1,503,046		14
15	Leasehold Improvements, at Historical Cost	1,071,470		15
16	Equipment, at Historical Cost	1,765,360		16
17	Accumulated Depreciation (book methods)	(2,944,979)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,493,863	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,423,646	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 139,609	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,840		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,140,439		31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,907		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Distributions</u>	5,423,368		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,768,163	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,768,163	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,655,487	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,423,650	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,006,288	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,006,288	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,172,839	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	(6,523,644)	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)	\$ 649,195	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)	\$ 1,655,483	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,652,047	1
2	Discounts and Allowances for all Levels	(413,236)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,238,811	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,158,741	6
7	Oxygen	32,177	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,190,918	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	18,242	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	298,753	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,485	19
20	Radiology and X-Ray	6,885	20
21	Other Medical Services	341,160	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 677,525	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,833	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,833	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc. Income/Vending Income/Loss on FI</u>	12,477	28
28a	<u>Proceeds from Sale of Business</u>	7,269,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,281,477	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,400,564	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,001,107	31
32	Health Care	2,664,649	32
33	General Administration	2,461,508	33
B. Capital Expense			
34	Ownership	208,214	34
C. Ancillary Expense			
35	Special Cost Centers	722,224	35
36	Provider Participation Fee	170,023	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,227,725	40
41	Income before Income Taxes (line 30 minus line 40)**	7,172,839	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,172,839	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 467,326	44
45	Private Pay - Net Inpatient Revenue	3,484,552	45
46	Medicare - Net Inpatient Revenue	1,196,182	46
47	Other-(specify) <u>Ins./Managed Care</u>	90,751	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,238,811	49

* 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 **Elmhurst Extended Care Ctr**

0003038

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,064	2,210	\$ 90,096	\$ 40.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,365	18,782	635,767	33.85	3
4	Licensed Practical Nurses	16,284	17,597	451,492	25.66	4
5	CNAs & Orderlies	67,783	72,254	923,674	12.78	5
6	CNA Trainees					6
7	Licensed Therapist	8,638	8,990	366,212	40.74	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,825	6,359	113,293	17.82	10
11	Social Service Workers	1,944	2,120	67,269	31.73	11
12	Dietician	1,944	2,178	69,679	31.99	12
13	Food Service Supervisor					13
14	Head Cook	1,995	2,315	44,456	19.20	14
15	Cook Helpers/Assistants	4,510	5,142	77,441	15.06	15
16	Dishwashers	8,129	8,528	83,855	9.83	16
17	Maintenance Workers	11,212	14,798	210,509	14.23	17
18	Housekeepers					18
19	Laundry	1,986	2,166	29,224	13.49	19
20	Administrator	1,984	2,080	115,319	55.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,944	2,080	67,362	32.39	23
24	Clerical	7,337	7,873	239,908	30.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,888	2,104	32,838	15.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,832	177,576	\$ 3,618,394 *	\$ 20.38	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	Monthly 38,970	09-03	36
37	Medical Records Consultant	20 1,170	10-03	37
38	Nurse Consultant	Monthly 55,155	10-03	38
39	Pharmacist Consultant	Monthly 2,818	10-03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	16 1,276	11-03	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	36 \$ 99,389		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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

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

