



Facility Name & ID Number LaSalle Health Care Center

# 0045740 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 \_\_\_\_\_

NA

	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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF		957	7,219	8,176	8
9	SNF/PED					9
10	ICF	21,803	4,680		26,483	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,803	5,637	7,219	34,659	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.02%

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

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 01/01/92

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

YES  Date 01/01/92 NO

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

YES  NO  If YES, enter number of beds certified 50 and days of care provided 6,850

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

LaSalle Healthcare Center

# 0045740

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	176,679	13,964	7,126	197,769		197,769	197,769		1	
2	Food Purchase		169,154		169,154		169,154	169,154		2	
3	Housekeeping	159,117	25,717		184,834		184,834	184,834		3	
4	Laundry	53,970	16,991		70,961		70,961	70,961		4	
5	Heat and Other Utilities			142,251	142,251		142,251	142,251		5	
6	Maintenance	61,275	13,901	59,701	134,877		134,877	9,169	144,046	6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	451,041	239,727	209,078	899,846		899,846	9,169	909,015	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			32,400	32,400		32,400	32,400		9	
10	Nursing and Medical Records	1,861,206	102,957	7,993	1,972,156		1,972,156	1,972,156		10	
10a	Therapy	413,951	8,672		422,623		422,623	422,623		10a	
11	Activities	81,102	8,416	1,857	91,375		91,375	91,375		11	
12	Social Services	50,296		2,802	53,098		53,098	53,098		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	2,406,555	120,045	45,052	2,571,652		2,571,652	2,571,652		16	
	<b>C. General Administration</b>										
17	Administrative	105,926		289,761	395,687		395,687	395,687		17	
18	Directors Fees									18	
19	Professional Services			98,189	98,189		98,189	(535)	97,654	19	
20	Dues, Fees, Subscriptions & Promotions			7,623	7,623		7,623	7,623		20	
21	Clerical & General Office Expenses	338,106	18,103	20,758	376,967		376,967	376,967		21	
22	Employee Benefits & Payroll Taxes			621,622	621,622		621,622	621,622		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			34,790	34,790		34,790	(34,790)		24	
25	Other Admin. Staff Transportation			4,265	4,265		4,265	4,265		25	
26	Insurance-Prop.Liab.Malpractice			10,037	10,037		10,037	10,037		26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	444,032	18,103	1,087,045	1,549,180		1,549,180	(35,325)	1,513,855	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,301,628	377,875	1,341,175	5,020,678		5,020,678	(26,156)	4,994,522	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

LaSalle Health Care Center  
Facility ID: 0045740  
12/31/2009

**Supplementary Information**  
**Schedule 3A**

Other Administration Staff Transportation

Automobile/Mileage (a/c 5338) 4,265

**L Schedule V C 25** 4,265

**SEE ACCOUNTANTS' COMPILATION REPORT**

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			42,000	42,000	42,000	50,239	92,239				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			62,400	62,400	62,400		62,400				33
34	Rent-Facility & Grounds			473,605	473,605	473,605		473,605				34
35	Rent-Equipment & Vehicles			20,943	20,943	20,943		20,943				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			598,948	598,948	598,948	50,239	649,187				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,967	1,642	146,609	146,609		146,609				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,540	54,540	54,540		54,540				42
43	Other (specify):* <b>Non-allowable cost</b>			148,549	148,549	148,549	(148,549)					43
44	<b>TOTAL Special Cost Centers</b>		144,967	204,731	349,698	349,698	(148,549)	201,149				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,301,628	522,842	2,144,854	5,969,324	5,969,324	(124,466)	5,844,858				45

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

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LaSalle Healthcare Center

# 0045740

Report Period Beginning: 1/1/09

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**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	50,239	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				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(115,865)	43		24
25	Fund Raising, Advertising and Promotional	(1,515)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(57,325)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (124,466)		\$	30

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

**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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (124,466)		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.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44					44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Cable TV expense	\$ (6,971)	43	1
2	Nonallowable Marketing expense	(15,418)	43	2
3	Labs - Part A	(8,149)	43	3
4	X-Rays - Part A	(543)	43	4
5	Nonallowable Radiology expense	(88)	43	5
6	Nonallowable Travel expense	(1,803)	24	6
7	Nonallowable Travel expense	(166)	24	7
8	Nonallowable Travel expense	(32,821)	24	8
9	Nonallowable Legal Fees	(535)	19	9
10	Reclass Assets to Repairs per Regulations	9,169	6	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>		(57,325)	49

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	Litchfield Health Care Center	Litchfield	NA		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V			NA				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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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							TOTAL	\$		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

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# 0045740

Report Period Beginning:

1/1/09

Ending: 12/31/09

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	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

SEE ACCOUNTANTS' COMPILATION REPORT



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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2008 report.		\$	<b>37,400</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	<b>2008</b>	\$	<b># 62,006</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>24,606</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>36,399</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			<b>Unreconciled Difference 1,395</b>	
<b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>62,400</b>	<b>7</b>

  

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	<b>2004</b>	<b>27,471</b>	<b>8</b>	
	<b>2005</b>	<b>26,862</b>	<b>9</b>	
	<b>2006</b>	<b>59,558</b>	<b>10</b>	
	<b>2007</b>	<b>57,118</b>	<b>11</b>	
	<b>2008</b>	<b>62,006</b>	<b>12</b>	

  

<b>FOR BHF USE ONLY</b>				
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

Accrual is based on prior year expense.

**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.**

SEE ACCOUNTANTS' COMPILATION REPORT



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>62,005.58</u>	\$ <u>62,005.58</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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

**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.**

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# 0045740 Report Period Beginning:

1/1/09 Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 31,694 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Building Improvements		1984	24,032		20			24,032	9
10	Building Improvements		1985	50,750		20			50,750	10
11	Building Improvements		1986	327		20			327	11
12	Building Improvements		1987	5,631		20			5,631	12
13	Building Improvements		1988	4,260		20			4,260	13
14	Building Improvements		1989	8,947		20	281	281	8,947	14
15	Building Improvements		1990	19,986		20	1,000	1,000	19,008	15
16	Building Improvements		1991	158,584		20	8,126	8,126	149,283	16
17	Building Improvements		1992	28,134		20	1,406	1,406	24,825	17
18	Building Improvements		1993	95,566		20	4,778	4,778	79,858	18
19	Building Improvements		1994	25,902		20	1,295	1,295	19,973	19
20	Building Improvements		1992	7,158		20	359	359	7,043	20
21	Building Improvements		1993	23,691		20	1,185	1,185	19,201	21
22	Building Improvements		1995	14,934		20	747	747	9,997	22
23	Building Improvements									23
24										24
25	Parking Lot Repairs		1996	2,400		20	120	120	1,608	25
26	Door & Frames		1996	1,679		20	84	84	1,130	26
27	Therapy Additions		1997	5,709		8.5			5,709	27
28	Therapy Room		1997	7,232		8.5			7,232	28
29	A/C repair		1996	1,120		20	56	56	772	29
30	Fire Alarm Systems		1996	14,927		20	746	746	9,999	30
31	Plumbing Repair		1996	772		20	39	39	513	31
32										32
33	Security System		1998	806		20	40	40	458	33
34	Exterior Sign/Flagpole		1998	3,221		20	268	268	3,017	34
35	Water Heater		1998	5,634		20	232	232	2,658	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number LaSalle Healthcare Center

# 0045740

Report Period Beginning:

1/1/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1:90 Gal Water Heater	1999	\$ 4,700	\$	10	\$ 157	\$ 157	\$ 4,700	37
38									38
39	7.5 Ton Carrier Roof Top Instl	2001	8,250		10	825	825	7,288	39
40	W/N/C RTU Condenser, Evapcoil	2001	4,842		15	323	323	2,799	40
41									41
42	Replace Commerical Water Heater	2002	6,401		10	640	640	5,111	42
43	6-Interior & 1-entrance Door	2002	15,415	771	20	771		5,654	43
44	Rprs Leak under Concrete Floor	2002	1,090	55	20	55		416	44
45	Repl Water Heater	2002	6,850	685	10	685		5,195	45
46									46
47									47
48	Rplc VCT Cove Base	2003	5,000	500	10	500		3,208	48
49	Rplc Trane Rooftop Unit	2003	4,595	460	10	460		3,181	49
50	Custom Made Book Cases/Serv Co	2003	6,523	435	15	435		2,864	50
51	Instl Charge- Nurse call System	2003	4,137	414	10	414		2,725	51
52	Nurse Call System Equipo	2003	6,407	461	10	461		3,073	52
53	Rplc VCT- Cove Base -Final Due	2003	5,412	541	10	541		3,472	53
54									54
55	AIA Document G702-Roof	2004	44,055	4,406	10	4,406		22,336	55
56	Roof Instl - App No 2 (Bal Due)	2004	100,283	10,028	10	10,028		50,697	56
57									57
58	Roof Repairs	2005	12,950	1,295	10	1,295		5,828	58
59	7.5 Ton RTU	2005	8,990	899	10	899		4,046	59
60	Plumbing Repair	2005	2,745	275	20	275		1,031	60
61	Plumbing Repair	2005	2,582	129	20	129		581	61
62									62
63	(2) 7.5 Ton RTU	2006	17,480		10	1,748	1,748	6,118	63
64									64
65	Fire Sprinklers	2007	3,900	89	10	390	301	973	65
66									66
67	Asphalt Repair	2008	7,724	193	20	193		386	67
68									68
69	Interior Door Replacements	2009	5,150		20	129	129	129	69
70	TOTAL (lines 4 thru 69)		\$ 796,883	\$ 21,636		\$ 46,521	\$ 24,885	\$ 598,042	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 364,390	\$ 20,364	\$ 40,509	\$ 20,145		\$ 340,256	71
72	Current Year Purchases	104,180		5,209	5,209		5,209	72
73	Fully Depreciated Assets	70,024					70,024	73
74								74
75	TOTALS	\$ 538,594	\$ 20,364	\$ 45,718	\$ 25,354		\$ 415,489	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									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)	\$ 1,335,477	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,239	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 50,239	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,013,531	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Nationwide Health Properties

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:	<u>1973</u>	<u>101</u>	<u>7/1/1989</u>	\$ <u>473,605</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>101</u>		\$ <u>473,605</u>			7

10. Effective dates of current rental agreement:

Beginning 7/1/1989

Ending 6/1/11

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2010 \$ \_\_\_\_\_

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

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

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 \_\_\_\_\_.

N/A

N/A

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 20,943 Description: Sch 14A

(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			<u>N/A</u>		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.

SEE ACCOUNTANTS' COMPILATION REPORT

**Provider Name** LaSalle Healthcare Center  
**Provider I.D. Number** 0045740  
**Year End** 12/31/09

**Rental Equipment Summary**

**Schedule 14A**

<u>Rental Costs</u>	<u>Amount</u>
Dishwasher	995
Copier	4,560
Medical Equipment	15,388
Total Rental for Movable Equipment	<u>20,943</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/1/09 Ending: 12/31/09  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.                  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1)	4141	hrs	\$ 159,347		\$	\$	4,141	\$ 159,347	1
2	Licensed Speech and Language Development Therapist	10A(1)	120	hrs	4,606				120	4,606	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2)	4616	hrs	177,626			8,672	4,616	186,298	4
5	Physician Care	39(3)		visits			1,642			1,642	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescripts				139,537		139,537	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)						5,226		5,226	12
13	Other (specify): <u>Ambulance</u>	39(2)						204		204	13
14	<b>TOTAL</b>				\$ 341,579		\$ 1,642	\$ 153,639	8,877	\$ 496,860	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/1/09 Ending: 12/31/09  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/09 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 60,323	\$ 60,323	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>106,481</u> )	918,205	918,205	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	137,873	137,873	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Patient Trust Bond</u>	900	900	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,117,301	\$ 1,117,301	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	269,706	796,883	15
16	Equipment, at Historical Cost	341,124	538,594	16
17	Accumulated Depreciation (book methods)	(282,882)	(1,013,531)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 327,948	\$ 321,946	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,445,249	\$ 1,439,247	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 422,809	\$ 422,809	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,457	204,457	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,399	36,399	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholding Liabilities</u>	527,673	527,673	36
37	<u>See Schedule 17A</u>	1,559,331	1,559,331	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,750,669	\$ 2,750,669	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,750,669	\$ 2,750,669	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,305,420)	\$ (1,311,422)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,445,249	\$ 1,439,247	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Schedule 17A

XV. BALANCE SHEET

Line 36: Other Current Liabilities (specify):

	<u>Operating</u>	<u>After Consolidation</u>
Due to/from Related Entities	1,339,518	1,339,518
Accrued Provider Assessment	(4,492)	(4,492)
SAVA Accruals	0	0
Accrued Management Fees	224,305	224,305
	<u>1,559,331</u>	<u>1,559,331</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,114,421)	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(36,862)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,151,283)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(154,140)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (154,137)	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)	\$ (1,305,420)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,479,449	1
2	Discounts and Allowances for all Levels	(1,883,687)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,595,762</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	953,599	6
7	Oxygen	10,460	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 964,059</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	200,662	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,155	19
20	Radiology and X-Ray	2,030	20
21	Other Medical Services	1,855	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 233,702</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>		26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>MCR PIP Payments (\$18,900); Other Rev (\$2,761)</u>	21,661	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 21,661</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,815,184</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	899,846	31
32	Health Care	2,571,652	32
33	General Administration	1,549,180	33
<b>B. Capital Expense</b>			
34	Ownership	598,948	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	295,158	35
36	Provider Participation Fee	54,540	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,969,324</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(154,140)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (154,140)</b>	43

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

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

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

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

Facility Name & ID Number LaSalle Healthcare Center

# 0045740

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	1,778	2,080	\$ 61,808	\$ 29.72	1
2	Assistant Director of Nursing	1,976	2,077	60,030	28.90	2
3	Registered Nurses	4,822	5,226	140,984	26.98	3
4	Licensed Practical Nurses	19,704	24,160	494,385	20.46	4
5	CNAs & Orderlies	60,701	68,232	880,709	12.91	5
6	CNA Trainees					6
7	Licensed Therapist	7,995	8,876	341,579	38.48	7
8	Rehab/Therapy Aides	5,477	6,290	85,208	13.55	8
9	Activity Director	5,843	6,249	81,102	12.98	9
10	Activity Assistants					10
11	Social Service Workers	3,370	3,805	50,296	13.22	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,080	40,392	19.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,129	13,523	136,287	10.08	15
16	Dishwashers					16
17	Maintenance Workers	3,596	3,872	61,275	15.83	17
18	Housekeepers	11,931	13,190	159,117	12.06	18
19	Laundry	4,410	4,704	53,970	11.47	19
20	Administrator	1,816	2,080	105,926	50.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,099	12,002	338,106	28.17	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	1,842	2,080	28,972	13.93	31
32	Other Health Care(specify)	8,052	8,929	181,482	20.33	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,413	189,455	\$ 3,301,628 *	\$ 17.43	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	264	\$ 7,126	1(3)	35
36	Medical Director	Monthly	23,400	9(3)	36
37	Medical Records Consultant	52	3,145	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	80	4,848	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,857	11(3)	44
45	Social Service Consultant	47	2,802	12(3)	45
46	Other(specify) <u>Psychology Svcs.</u>	Monthly	9,000	9(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	473	\$ 52,178		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LaSalle Healthcare Center

# 0045740

Report Period Beginning: 1/1/09

Ending: 12/31/09

**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	
Lori Walsh	Administrator	0	\$ 105,926	Workers' Compensation Insurance	\$ 138,987	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	19,959	Advertising: Employee Recruitment	132	
				FICA Taxes	252,575	Health Care Worker Background Check		
				Employee Health Insurance	209,157	(Indicate # of checks performed <u>103</u> )	3,479	
				Employee Meals		Patient Background Checks	<u>102</u> 1,597	
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Licenses & Fees	932	
				Employee Relations	605	Misc. Dues & Subscriptions	488	
				Employee Physicals	339			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 105,926	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,623		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
Family Senior Care			\$ 289,761				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 289,761	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type	Amount		Description	Line #	Amount	Amount	
Adelpo LLC	Computer Maintenance	\$ 2,400		N/A			Out-of-State Travel \$	
IT Management	Computer Maintenance	35,344					N/A	
IT Management	Data Processing	13,120					In-State Travel	
Ivans Inc	Data Processing	9,742					N/A	
Hamlin & Burton	Risk Management	1,000					Seminar Expense	
Law Offices of Shannon Harvey	Legal	535					N/A	
Myers & Miller LLC	Legal	2,522					Entertainment Expense ( )	
RSM McGladrey	Accounting	22,830					(agree to Sch. V, line 24, col. 8)	
IT Management	Internet Services	3,030					TOTAL	
Payday USA	Payroll Processing	7,666					\$	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 98,189	TOTAL			\$	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

LaSalle Health Care Center  
Provider ID #: 0045740  
12/31/2009

**Schedule 21A**

XIX.C. Professional Services

Total Professional Services	From PG21	98,189
Less: Nonallowable Legal Fees (Law Offices of Shannon Harvey)		<u>(535)</u>
		97,654
Schedule V, Line 19, Column 8		<u>97,654</u>
Variance		<u><u>-</u></u>

**See Accountants' Compilation Report**

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number LaSalle Healthcare Center

# 0045740

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,804 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. NA
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,540  
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

## SEE ACCOUNTANTS' COMPILATION REPORT