

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0049502</u></p> <p>Facility Name: <u>MCALLISTER NURSING & REHAB</u></p> <p>Address: <u>18300 S LAVERGNE</u> <u>TINLEY PARK</u> <u>60477</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(708) 798-2272</u> Fax # <u>(708) 798-2298</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/17/08</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 <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>01/01/2012</u> to <u>12/31/2012</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) <u>ELI ATKIN</u> (Title) <u>MEMBER</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p style="text-align: right; margin-top: 10px;">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) <u>ELI ATKIN</u> (Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ELI ATKIN</u> (Title) <u>MEMBER</u>							
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>							

Facility Name & ID Number MCALLISTER NURSING & REHAB

0049502 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,914	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	11,712	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,626	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	15,870	2,448	4,376	22,694	8
9	SNF/PED					9
10	ICF	8,457	622	338	9,417	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,327	3,070	4,714	32,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.04%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 12/01/08

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

YES Date 12/01/08 NO

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

YES NO If YES, enter number of beds certified 79 and days of care provided 3,837

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number

MCALLISTER NURSING & REHAB

0049502

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	222,363	7,957	2,174	232,494		232,494	232,494			1
2	Food Purchase		198,519		198,519	(10,651)	187,868	186,540			2
3	Housekeeping		7,043		7,043		7,043	7,043			3
4	Laundry		6,666	96,945	103,611		103,611	103,611			4
5	Heat and Other Utilities			78,416	78,416		78,416	78,416			5
6	Maintenance	37,752	12,091	179,131	228,974		228,974	228,974			6
7	Other (specify):*			12,472	12,472		12,472	12,472			7
8	TOTAL General Services	260,115	232,276	369,138	861,529	(10,651)	850,878	849,550			8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200	7,200			9
10	Nursing and Medical Records	1,498,000	91,811	9,498	1,599,309		1,599,309	1,599,309			10
10a	Therapy	85,146		114	85,260		85,260	85,260			10a
11	Activities	82,317	5,061		87,378		87,378	87,378			11
12	Social Services	44,275		930	45,205		45,205	45,205			12
13	CNA Training										13
14	Program Transportation			1,758	1,758		1,758	1,758			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,709,738	96,872	19,500	1,826,110		1,826,110	1,826,110			16
	C. General Administration										
17	Administrative	232,779		156,332	389,111		389,111	389,111			17
18	Directors Fees										18
19	Professional Services			99,022	99,022		99,022	99,022			19
20	Dues, Fees, Subscriptions & Promotions			97,609	97,609		97,609	5,189	(92,420)		20
21	Clerical & General Office Expenses	173,726	18,371	65,335	257,432		257,432	246,067	(11,365)		21
22	Employee Benefits & Payroll Taxes			536,211	536,211	10,651	546,862	479,725	(67,137)		22
23	Inservice Training & Education			1,181	1,181		1,181	1,181			23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			10,938	10,938		10,938	1,094	(9,844)		25
26	Insurance-Prop.Liab.Malpractice			223,431	223,431		223,431	223,431			26
27	Other (specify):*			23,000	23,000		23,000		(23,000)		27
28	TOTAL General Administration	406,505	18,371	1,213,059	1,637,935	10,651	1,648,586	1,444,820	(203,766)		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,376,358	347,519	1,601,697	4,325,574		4,325,574	4,120,480	(205,094)		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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	2,174
		0
		2,174
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	945
	CONTRACTED LAUNDRY SERVICES	96,000
		96,945
5	HEAT & OTHER UTILITIES	
	GAS HEAT	19,822
	ELECTRICITY	40,281
	WATER	13,677
	CABLE TV - LOBBY	4,636
		0
		78,416
6	MAINTENANCE	
	GROUNDS MAINTENANCE	10,177
	PAINTING & DECORATING	57
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	17,293
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	4,140
	EXTERMINATING SERVICE	3,300
	FIRE SERVICE	11,476
	CONTRACTED BUILDING MAINT	132,688
		0
		0
		0
		179,131
7	OTHER	
	SCAVENGER	11,522
	SECURITY SERVICE	950
		0
		0
		12,472
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,200
		7,200

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	1,647
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
	NURSING	2,746
	DENTAL	5,105
		9,498
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	114
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		114
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	930
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		930
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,758
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	156,332
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,477
	ADMINISTRATIVE CONSULTANTS XIX C	22,200
	PROFESSIONAL FEES XIX C	64,345
		0
		99,022
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,816
	EMPLOYEE WANT ADS XIX F	415
	CONTRIBUTIONS VI 20 XIX F	76,604
	DUES & SUBSCRIPTIONS XIX F	2,307
	LICENSES & PERMITS XIX F	2,357
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	110
	PATIENT BACKGROUND CHECKS XIX F	0
		97,609
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,282
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	11,365
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	48,688
	MESSENGER SERVICE	0
		0
		65,335

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	181,801
	UNEMPLOYMENT COMPENSATION XIX D	109,938
	WORKERS COMPENSATION INSURANC XIX D	66,964
	HOSPITALIZATION INSURANCE XIX D	93,764
	EMPLOYEE BENEFITS - OTHER XIX D	2,829
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	67,137
	PENSION/PROFIT SHARING PLANS XIX D	13,778
	CHICAGO HEAD TAX XIX D	0
		0
		536,211
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,181
		1,181
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,938
		10,938
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	223,431
		223,431
27	OTHER	
	BAD DEBTS VI 24	23,000
		23,000

GRAND TOTAL COLUMN 3 OTHER

1,601,697

MCALLISTER NURSING & REHAB
SCHEDULES
12/31/2012

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	198,519
LESS SALES TAX	<u>(1,328)</u>
NET FOOD	197,191
TOTAL PATIENT CENSUS	32,111
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	96,333
ADD # EMPLOYEE MEALS/DAY	15
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	5,490
PATIENT MEALS	96,333
ADD EMPLOYEE MEALS	<u>5,490</u>
TOTAL MEALS/YEAR	101,823
NET FOOD	197,191
DIVIDE TOTAL MEALS/YEAR	<u>101,823</u>
COST PER MEAL	1.94
TIMES EMPLOYEE MEALS	<u>5,490</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>10,651</u>

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	
	D. Ownership											
30	Depreciation			15,084	15,084		15,084	199,962	215,046			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,527	84,527		84,527	238,836	323,363			32
33	Real Estate Taxes			369,444	369,444		369,444		369,444			33
34	Rent-Facility & Grounds			392,990	392,990		392,990	(392,990)				34
35	Rent-Equipment & Vehicles			16,385	16,385		16,385		16,385			35
36	Other (specify):*											36
37	TOTAL Ownership			878,430	878,430		878,430	45,808	924,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,390	210,590	315,980		315,980		315,980			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			330,496	330,496		330,496		330,496			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		105,390	541,086	646,476		646,476		646,476			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,376,358	452,909	3,021,213	5,850,480		5,850,480	(159,286)	5,691,194			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				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	5,972	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,328)	2		13
14	Non-Care Related Interest	(32,775)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(11,365)	21		18
19	Entertainment		20		19
20	Contributions	(76,604)	20		20
21	Owner or Key-Man Insurance	(67,137)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,000)	27		24
25	Fund Raising, Advertising and Promotional	(15,816)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(9,844)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (231,897)		\$	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)	72,611		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 72,611		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (159,286)		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.		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

MCALLISTER NURSING & REHAB

ID# 0049502

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NON ALLOWABLE TRAVEL	\$ (9,844)	25	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(9,844)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCALLISTER NURSING & REHAB# 0049502

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	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	(1,328)	0	(1,328)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(92,420)	0	0	0	0	0	0	0	0	0	0	(92,420)	20
21	Clerical & General Office Expenses	(11,365)	0	0	0	0	0	0	0	0	0	0	(11,365)	21
22	Employee Benefits & Payroll Taxes	(67,137)	0	0	0	0	0	0	0	0	0	0	(67,137)	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	(9,844)	0	0	0	0	0	0	0	0	0	0	(9,844)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(23,000)	0	0	0	0	0	0	0	0	0	0	(23,000)	27
28	TOTAL General Administration	(203,766)	0	(203,766)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(205,094)	0	(205,094)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCALLISTER NURSING & REHAB# 0049502

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,972	193,990	0	0	0	0	0	0	0	0	0	199,962	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,775)	271,611	0	0	0	0	0	0	0	0	0	238,836	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(392,990)	0	0	0	0	0	0	0	0	0	(392,990)	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	(26,803)	72,611	0	45,808	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(231,897)	72,611	0	0	0	0	0	0	0	0	0	(159,286)	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
Yael Atkin	44	Oakridge Healthcare Center, LLC	Hillside, Ill	McAllister		
Donna Atkin	44			Property, LLC	Tinley Park Ill	Real Estate
Jay Orlinsky	5					
Helen Lacek	7			Oakridge	Hillside Ill	Real Estate
				Property, LLC		

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 392,990	MCALLISTER PROPERTY, LLC		\$	\$ (392,990)	1
2	V	30 DEPRECIATION				193,990	193,990	2
3	V	32 INTEREST				253,361	253,361	3
4	V	32 AMORT OF LOAN COSTS				18,250	18,250	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		\$ 392,990			\$ 465,601	\$ * 72,611	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 MCALLISTER NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	ELISHA ATKIN	OTHER ADMIN	Administration					SALARY	\$ 105,168	17-1	1
2			Purchases								2
3	JOEL ATKIN	OTHER ADMIN	Administration					SALARY	49,491	17-1	3
4											4
5											5
6											6
7											7
8	Yael ATKIN	MEMBER	ADMIN.	44.00				mgmt	78,166	17-3	8
9											9
10	DONNA ATKIN	MEMBER	ADMIN.	44.00				mgmt	78,166	17-3	10
11											11
12											12
13								TOTAL	\$ 310,991		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 MCALLISTER NURSING & REHAB

0049502

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

MCALLISTER NURSING & REHAB

0049502

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	MC ALLISTER PROPERTY, LLC						\$	\$			\$	1						
2	FIRST MERIT BANK		X	MORTGAGE (NET OF INT INCOME)		5/24/11	4,600,000	4,552,945	7/31/17			253,361	2					
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		8/1/12						18,250	3					
4													4					
5	INSURANCE											7,326	5					
Working Capital																		
6	FIRST MERIT BANK		X	WORKING CAPITAL	INT ONLY	3/17/08	600,000	769,105	REVOLV	5.0000		42,678	6					
7													7					
8	INFINITY FINANCIAL		X	AUTO		1/10/10	59,255	12,061		2.9000		1,748	8					
9	TOTAL Facility Related					\$1,063.39	\$ 5,259,255	\$ 5,334,111				\$ 323,363	9					
B. Non-Facility Related*																		
10	BED TAX											6,086	10					
11	REAL ESTATE TAXES											19,048	11					
12	NATIONAL GOV'T SERVICES												12					
13	JACK ATKIN											7,641	13					
14	TOTAL Non-Facility Related						\$	\$				\$ 32,775	14					
15	TOTALS (line 9+line14)						\$ 5,259,255	\$ 5,334,111				\$ 356,138	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

* 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 2011 report.		\$	317,404		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.)		\$	315,523		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,881)		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	371,325		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.		\$	369,444		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	231,660	8	FOR BHF USE ONLY	
	2008	287,500	9	13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
	2009	247,527	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2010	247,404	11	15	LESS REFUND FROM LINE 6 \$ 15
	2011	336,095	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 100%					
OF THE PRIOR YEAR REAL ESTATE TAX BILL PLUS 90,571.95 OWED					
ON 2011 TAX BILL, MINUS 55,341.65 EST REDUCTION ON 2012					
THE PAYMENT ON LINE 2 APPLIES TO THE \$70,000 FOR 2010 BILL PLUS \$245,523 FOR 2011 BILL					

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCALLISTER NURSING & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049502

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>28-33-403-043-0000</u>	<u>NURSING HOME</u>	\$ <u>285,544.12</u>	\$ <u>285,544.12</u>
2. <u>28-33-403-007-0000</u>	<u>NURSING HOME</u>	\$ <u>46,854.71</u>	\$ <u>46,854.71</u>
3. <u>28-33-403-008-0000</u>	<u>NURSING HOME</u>	\$ <u>3,696.06</u>	\$ <u>3,696.06</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>336,094.89</u></u>	\$ <u><u>336,094.89</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

N/A

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: _____ 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>2008</u>	<u>\$ 726,776</u>	1
2					2
3	TOTALS			\$ 726,776	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	111	2008		\$ 2,907,102	\$ 105,713	27.5	\$ 105,713	\$	\$ 506,541	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	DOORS	2008		4,517	164	27.5	164		800	9
10	COVE BASE FLOORING (LANDLORD)	2009		2,520	92	27.5	92		326	10
11	DOORS (LANDLORD)	2009		5,131	186	27.5	186		659	11
12	HANDRAILS (LANDLORD)	2009		16,217	590	27.5	590		2,089	12
13	2 NURSE STATIONS (LANDLORD)	2009		3,600	131	27.5	131		464	13
14	FIRE SPRINKLER SYSTEM (LANDLORD)	2009		2,500	91	27.5	91		322	14
15	PYROCHEM SYSTEM (LANDLORD)	2009		3,156	115	27.5	115		407	15
16	NURSE CALL LIGHT SYSTEM (LANDLORD)	2009		5,200	189	27.5	189		669	16
17	SPRINKLERS (LANDLORD)	2009		38,000	1,382	27.5	1,382		4,895	17
18	SIGNS (LANDLORD)	2009		4,781	174	27.5	174		616	18
19	ROOF (LANDLORD)	2009		11,000	399	27.5	399		1,414	19
20	CARPETING (LANDLORD)	2009		4,087	235	5	817	582	1,635	20
21	PAINTING (LANDLORD)	2009		53,725	3,094	5	10,745	7,651	21,491	21
22	CURTAINS (LANDLORD)	2009		19,732	1,137	5	3,946	2,809	7,892	22
23	BLINDS (LANDLORD)	2009		4,560	263	5	912	649	1,824	23
24	DRAPES (LANDLORD)	2010		6,677	641	5	1,335	694	1,736	24
25	DRAPES (LANDLORD)	2010		3,662		5	732	732	1,098	25
26	OUTDOOR LIGHTING (LANDLORD)	2010		7,380	492	15	492		1,230	26
27	DRAPES (LANDLORD)	2010		2,817	102	27.5	102		234	27
28	DRAIN LINE (LANDLORD)	2011		3,500	127	27.5	127		132	28
29	HOT WATER HEATER	2012		5,488	42	27.5	42		42	29
30	DRY PIPE VALVE FOR FIRE PROTECTION SYSTEM	2012		3,740	28	27.5	28		28	30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **MCALLISTER NURSING & REHAB**

0049502

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1	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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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)		\$ 3,119,092	\$ 115,387		\$ 128,504	\$ 13,117	\$ 556,544	70

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

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	\$ 140,435	\$ 8,332	\$ 14,044	\$ 5,712		\$ 50,913	71
72	Current Year Purchases	4,432	2,659	222	(2,437)		222	72
73	Fully Depreciated Assets							73
74	REL PARTY		78,767	65,000	(13,767)			74
75	TOTALS	\$ 144,867	\$ 89,758	\$ 79,266	\$ (10,492)		\$ 51,135	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	FACILITY	1996 CHEVY K1500	2009	\$ 8,500	\$ 979	\$ 850	\$ (129)		\$ 3,400	76
77	FACILITY	INFINITI G37 CONVERTIBLE	2010	64,255	2,950	6,426	3,476		19,278	77
78										78
79										79
80	TOTALS			\$ 72,755	\$ 3,929	\$ 7,276	\$ 3,347		\$ 22,678	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)	\$ 4,063,490	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 209,074	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 215,046	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,972	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 630,357	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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>392,990</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>392,990</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 16,385 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></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			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	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	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39-3	hrs	\$				\$ 83,290				\$ 83,290	1
2	Licensed Speech and Language Development Therapist	39-3	hrs										2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39-3	hrs				120,558					120,558	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39-2	# of prescrpts						99,696			99,696	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Dental Service,Radiology,Laboratory Other (specify): <u>MED. SUPPLIES</u>	39-3 39-2					6,742		5,694			6,742 5,694	13
14	TOTAL			\$			\$ 210,590	\$	105,390	\$		\$ 315,980	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 **MCALLISTER NURSING & REHAB**# **0049502**Report Period Beginning: **01/01/2012**

Ending:

12/31/2012**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2012**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 54,015	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (91,574))	1,331,411		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	269,806		6
7	Other Prepaid Expenses	7,971		7
8	Accounts Receivable (owners or related parties)	1,070,834		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,734,037	\$	10
	B. Long-Term Assets			
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	4,517		15
16	Equipment, at Historical Cost	217,622		16
17	Accumulated Depreciation (book methods)	(161,638)		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 (spec develop. Cost	125,793		22
23	Other(specify): <u>due from mcallister properties</u>	244,885		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 431,179	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,165,216	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,119,920	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	769,105		29
30	Accrued Salaries Payable	162,963		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,509		31
32	Accrued Real Estate Taxes(Sch.IX-B)	371,325		32
33	Accrued Interest Payable	12,524		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Infiniti Financial Services</u>	12,061		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,488,407	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,557		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)	\$ 17,557	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,505,964	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 659,252	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,165,216	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 321,726	1
2	Restatements (describe):		2
3	STATE REPLACEMENT TAX	(7,728)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 313,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	375,254	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	(30,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 345,254	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)	\$ 659,252	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	\$ 6,206,741	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,206,741	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,206,741	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	861,529	31
32	Health Care	1,826,110	32
33	General Administration	1,637,935	33
B. Capital Expense			
34	Ownership	878,430	34
C. Ancillary Expense			
35	Special Cost Centers	315,980	35
36	Provider Participation Fee	330,496	36
D. Other Expenses (specify):			
37			37
38	OTHER EXPENSE ADJUSTMENT	(18,993)	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,831,487	40
41	Income before Income Taxes (line 30 minus line 40)**	375,254	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 375,254	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,983,655	44
45	Private Pay - Net Inpatient Revenue	460,274	45
46	Medicare - Net Inpatient Revenue	1,615,578	46
47	Other-(specify) <u>INSURANCE</u>	147,234	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,206,741	49

**TAX RETURN IS ON EXTENSION

* 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.

*** 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 **MCALLISTER NURSING & REHAB**

0049502

Report Period Beginning: **01/01/2012**

Ending:

12/31/2012

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	1,257	1,291	\$ 50,818	\$ 39.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,707	4,822	154,423	32.02	3
4	Licensed Practical Nurses	24,759	26,063	628,525	24.12	4
5	CNAs & Orderlies	57,014	59,916	609,028	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,688	1,777	85,146	47.92	8
9	Activity Director	1,892	2,102	34,808	16.56	9
10	Activity Assistants	4,303	4,732	47,509	10.04	10
11	Social Service Workers	2,032	2,074	44,275	21.35	11
12	Dietician					12
13	Food Service Supervisor	2,247	2,451	42,452	17.32	13
14	Head Cook	2,003	2,174	20,576	9.46	14
15	Cook Helpers/Assistants	9,761	10,769	113,082	10.50	15
16	Dishwashers	3,593	3,981	46,253	11.62	16
17	Maintenance Workers	1,948	2,091	37,752	18.05	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,163	2,171	78,120	35.98	20
21	Assistant Administrator	4,263	4,263	154,659	36.28	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,082	11,832	173,726	14.68	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	1,854	1,970	55,206	28.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,566	144,479	\$ 2,376,358 *	\$ 16.45	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	M	\$ 0	1-3	35
36	Medical Director	O	7,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,647	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		114	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,961		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
GERALDINE WAGNER	ADMINISTRATOR		\$ 78,120	Workers' Compensation Insurance		\$ 66,964	IDPH License Fee	\$
			0	Unemployment Compensation Insurance		109,938	Advertising: Employee Recruitment	415
JOEL ATKIN	OTHER ADMIN		49,491	FICA Taxes		181,801	Health Care Worker Background Check	110
ELI ATKIN	OTHER ADMIN		105,168	Employee Health Insurance		93,764	(Indicate # of checks performed)	
				Employee Meals		10,651	Patient Background Checks	0
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	76,604
				EMPLOYEE BENEFITS - OTHER		2,829	MARKETING/ADV/PROMO	15,816
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	4,664
				PENSION/PROFIT SHARING PLANS		13,778	MGMT CO ALLOC	
				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(76,604)
				INSURANCE - EXECUTIVE LIFE		67,137	Less: Public Relations Expense	(0)
				INSURANCE - EXECUTIVE LIFE VI 21		(67,137)	Non-allowable advertising	(15,816)
							Yellow page advertising	(0)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 232,779	TOTAL (agree to Schedule V, line 22, col.8)		\$ 479,725	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,189
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
YEAL ATKIN - MANAGEMENT FEES			\$ 78,166			\$	Out-of-State Travel	\$
DONNA ATKIN - MANAGEMENT FEES			78,166					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 156,332				Seminar Expense	0
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount	Description	Line #	Amount	(agree to Sch. V, line 24, col. 8)	
			\$			\$	TOTAL	\$
SEE SCHEDULE ATTACHED			99,022					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 99,022	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number MCALLISTER NURSING & REHAB

0049502

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 330,496
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. \$ 10,651 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.