



Facility Name & ID Number MCALLISTER NURSING AND REHAB

# 0049502 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	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	28,835	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	11,680	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	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	16,153	988	5,218	22,359	8
9	SNF/PED					9
10	ICF	7,861	699	98	8,658	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,014	1,687	5,316	31,017	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.56%

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 4,749

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name &amp; ID Number

MCALLISTER NURSING AND REHAB

# 0049502

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	232,256	13,999	7,364	253,619		253,619		253,619		1
2	Food Purchase		179,690		179,690	(9,910)	169,780	(1,100)	168,680		2
3	Housekeeping	10,326	10,554		20,880		20,880		20,880		3
4	Laundry	4,725	18,339	92,838	115,902		115,902		115,902		4
5	Heat and Other Utilities			82,114	82,114		82,114		82,114		5
6	Maintenance	42,315	28,340	209,849	280,504		280,504		280,504		6
7	Other (specify):*			12,429	12,429		12,429		12,429		7
8	<b>TOTAL General Services</b>	289,622	250,922	404,594	945,138	(9,910)	935,228	(1,100)	934,128		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,600	10,600		10,600		10,600		9
10	Nursing and Medical Records	1,539,735	96,272	10,843	1,646,850		1,646,850		1,646,850		10
10a	Therapy	163,136			163,136		163,136		163,136		10a
11	Activities	83,529	11,890		95,419		95,419		95,419		11
12	Social Services	44,951			44,951		44,951		44,951		12
13	CNA Training										13
14	Program Transportation			132	132		132		132		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,831,351	108,162	21,575	1,961,088		1,961,088		1,961,088		16
	<b>C. General Administration</b>										
17	Administrative	257,504		24,147	281,651		281,651		281,651		17
18	Directors Fees										18
19	Professional Services			77,335	77,335		77,335		77,335		19
20	Dues, Fees, Subscriptions & Promotions			25,831	25,831		25,831	(14,695)	11,136		20
21	Clerical & General Office Expenses	137,721	38,112	45,749	221,582		221,582		221,582		21
22	Employee Benefits & Payroll Taxes			488,061	488,061	9,910	497,971		497,971		22
23	Inservice Training & Education			3,089	3,089		3,089	(600)	2,489		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			225,124	225,124		225,124		225,124		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	395,225	38,112	889,336	1,322,673	9,910	1,332,583	(15,295)	1,317,288		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,516,198	397,196	1,315,505	4,228,899		4,228,899	(16,395)	4,212,504		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	7,052
	REPAIRS & MAINTENANCE	312
		0
		7,364
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,801
	CONTRACTED LAUNDRY SERVICE	91,037
		92,838
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	27,675
	ELECTRICITY	39,724
	WATER	11,951
	CABLE TV - LOBBY	2,764
		0
		82,114
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	10,855
	PAINTING & DECORATING	760
	BUILDING REPAIRS	2,200
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	36,167
	ELEVATOR MAINTENANCE & REPAIR	398
	OUTSIDE LABOR	5,147
	EXTERMINATING SERVICE	3,540
	FIRE SERVICE	6,857
	CONTRACTED BUILDING MAINTENANCE	143,925
		0
		0
		0
		209,849
7	<b>OTHER</b>	
	SCAVENGER	11,463
	SECURITY SERVICE	966
		0
		0
		12,429
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	10,600
		10,600

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,851
	PURCHASED SERVICES	3,108
	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	1,676
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	4,208
		0
		0
		10,843
10a	<b>THERAPY</b>	
	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	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>		
	PATIENT TRANSPORTATION		132
			0
17	<b>ADMINISTRATIVE</b>		
	MANAGEMENT FEES	XIX B	24,147
	<b>DIRECTORS FEES</b>		
18	DIRECTORS FEES		0
19	<b>PROFESSIONAL SERVICES</b>		
	DATA PROCESSING	XIX C	19,495
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	57,840
			0
			77,335
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	14,695
	EMPLOYEE WANT ADS	XIX F	125
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	5,567
	LICENSES & PERMITS	XIX F	5,444
	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	0
	PATIENT BACKGROUND CHECKS	XIX F	0
			25,831
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		19,649
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	0
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		26,100
	MESSENGER SERVICE		0
			0
			45,749

LINE		SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>		
	FICA TAXES	XIX D	192,479
	UNEMPLOYMENT COMPENSATION	XIX D	119,716
	WORKERS COMPENSATION INSURANC	XIX D	70,302
	HOSPITALIZATION INSURANCE	XIX D	86,896
	EMPLOYEE BENEFITS - OTHER	XIX D	7,366
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	11,302
	CHICAGO HEAD TAX	XIX D	0
			0
			488,061
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>		
	EDUCATION & SEMINARS		3,089
			3,089
24	<b>TRAVEL &amp; SEMINARS</b>		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	<b>ADMIN. STAFF TRANSPORTATION</b>		
	TRANSPORTATION - STAFF		0
			0
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>		
	GENERAL INSURANCE		225,124
			225,124
27	<b>OTHER</b>		
	BAD DEBTS	VI 24	0
			0

GRAND TOTAL COLUMN 3 OTHER

1,315,505

**MCALLISTER NURSING AND REHAB  
SCHEDULES  
12/31/2013**

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

TOTAL FOOD PURCHASE	179,690
LESS SALES TAX	<u>(1,100)</u>
NET FOOD	178,590

TOTAL PATIENT CENSUS	31,017
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	93,051

ADD # EMPLOYEE MEALS/DAY	15
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	5,475

PATIENT MEALS	93,051
ADD EMPLOYEE MEALS	<u>5,475</u>
TOTAL MEALS/YEAR	98,526

NET FOOD	178,590
DIVIDE TOTAL MEALS/YEAR	<u>98,526</u>

COST PER MEAL	1.81
TIMES EMPLOYEE MEALS	<u>5,475</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><b>9,910</b></u>

Facility Name &amp; ID Number

MCALLISTER NURSING AND REHAB

#0049502

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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			24,174	24,174		24,174	195,472	219,646			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,890	72,890		72,890	217,854	290,744			32
33	Real Estate Taxes			261,693	261,693		261,693		261,693			33
34	Rent-Facility & Grounds			473,246	473,246		473,246	(473,246)				34
35	Rent-Equipment & Vehicles			18,329	18,329		18,329		18,329			35
36	Other (specify):* <b>amort- comp software</b>			528	528		528		528			36
37	<b>TOTAL Ownership</b>			850,860	850,860		850,860	(59,920)	790,940			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,105	219,218	348,323		348,323		348,323			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,425	225,425		225,425		225,425			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		129,105	444,643	573,748		573,748		573,748			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,516,198	526,301	2,611,008	5,653,507		5,653,507	(76,315)	5,577,192			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	
	<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	40,511	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	(1,100)	2		13
14	Non-Care Related Interest	(22,758)	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		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(14,695)	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	(600)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 1,358		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(77,673)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (77,673)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (76,315)		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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

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

MCALLISTER NURSING AND REHAB

ID# 0049502

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	EDUCATION & SEMINARS	\$ (600)	23	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(600)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCALLISTER NURSING AND REHAB# 0049502

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,100)	0	0	0	0	0	0	0	0	0	0	(1,100)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,100)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,100)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(14,695)	0	0	0	0	0	0	0	0	0	0	(14,695)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(600)	0	0	0	0	0	0	0	0	0	0	(600)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(15,295)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(15,295)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(16,395)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(16,395)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number MCALLISTER NURSING AND REHAB# 0049502

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	40,511	154,961	0	0	0	0	0	0	0	0	0	195,472	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,758)	240,612	0	0	0	0	0	0	0	0	0	217,854	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(473,246)	0	0	0	0	0	0	0	0	0	(473,246)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>17,753</b>	<b>(77,673)</b>	<b>0</b>	<b>(59,920)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	1,358	(77,673)	0	0	0	0	0	0	0	0	0	(76,315)	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		
				Property, LLC	Hillside	Real Estate

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	\$ 473,246	MCALLISTER PROPERTY, LLC		\$	\$ (473,246)	1
2	V	30 DEPRECIATION				154,961	154,961	2
3	V	32 INTEREST				234,747	234,747	3
4	V	32 AMORT OF LOAN COSTS				5,865	5,865	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		\$ 473,246			\$ 395,573	\$ * (77,673)	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 AND REHAB # 0049502 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

1	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	ELISHA ATKIN	OTHER ADMIN	ADMINISTRATIVE	oakridge healthcare	SEE			\$ 103,138	17-1	1
2		PURCHASES		88,500	ATTACHED					2
3	JOEL ATKIN	OTHER ADMIN	ADMINISTRATIVE		SEE			48,060	17-1	3
4					ATTACHED					4
5	HELEN LACEK		7.00					38,626	17-1	5
6										6
7										7
8	Yael ATKIN	MEMBER	ADMINISTRATIVE	44.00	oakridge healthcare	SEE		12,073	17-3	8
9				88,500	ATTACHED					9
10	DONNA ATKIN	MEMBER	ADMINISTRATIVE	44.00		SEE		12,074	17-3	10
11					ATTACHED					11
12										12
13							TOTAL	\$ 213,971		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 AND REHAB

# 0049502

Report Period Beginning: 01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name &amp; ID Number

MCALLISTER NURSING AND REHAB

# 0049502

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	MC ALLISTER PROPERTY, LLC						\$	\$			\$	1						
2	FIRST MERIT BANK		X	MORTGAGE		5/24/11	4,600,000	4,303,827	7/31/17			234,747	2					
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		8/1/12						5,865	3					
4													4					
5	RBS CITIZENS		X	AUTO		5/14/13	49,551	48,792	5/14/19	0.0290		806	5					
<b>Working Capital</b>																		
6	FIRST MERIT BANK		X	WORKING CAPITAL		REVOLV		924,000		REVOLV		41,123	6					
7	FIRST INSURANCE FUND		X	INSURANCE POLICIES FIN								7,971	7					
8	INFINITY FINANCIAL		X	AUTO								232	8					
9	TOTAL Facility Related					\$750.65	\$ 4,649,551	\$ 5,276,619			\$	290,744	9					
<b>B. Non-Facility Related*</b>																		
10	BED TAX											6,078	10					
11	REAL ESTATE TAXES											16,194	11					
12	NATIONAL GOV'T SERVICES												12					
13	JACK ATKIN											486	13					
14	TOTAL Non-Facility Related						\$	\$			\$	22,758	14					
15	TOTALS (line 9+line14)						\$ 4,649,551	\$ 5,276,619			\$	313,502	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.		\$	<b>371,325</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>371,795</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>470</b>		<b>3</b>
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>261,223</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>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>261,693</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<b>287,500</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2009	<b>247,527</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2012 \$
	2010	<b>247,404</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	2011	<b>336,095</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$
	2012	<b>301,223</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED</b>					
<b>ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL LESS A ANTICIPATED REDUCTION OF \$60,000</b>					
<b>PLUS \$20,000 BALANCE DUE ON 2012 BILL</b>					
<b>THE PAYMENT ON LINE 2 APPLIES TO BALANCE OF 2011 OF \$90572 AND \$281,223 FOR 2012</b>					

**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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCALLISTER NURSING AND REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049502

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D)
<u>Tax 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>251,808.24</u>	\$ <u>251,808.24</u>
2. <u>28-33-403-007-0000</u>	<u>NURSING HOME</u>	\$ <u>46,017.21</u>	\$ <u>46,017.21</u>
3. <u>28-33-403-008-0000</u>	<u>NURSING HOME</u>	\$ <u>3,397.80</u>	\$ <u>3,397.80</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>301,223.25</u></u>	\$ <u><u>301,223.25</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ 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	<b>TOTALS</b>			\$ <u>726,776</u>	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	\$	\$ 612,254	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	DOORS	2008		4,517	164	27.5	164		964	9
10	COVE BASE FLOORING (LANDLORD)	2009		2,520	92	27.5	92		418	10
11	DOORS (LANDLORD)	2009		5,131	186	27.5	186		845	11
12	HANDRAILS (LANDLORD)	2009		16,217	590	27.5	590		2,679	12
13	2 NURSE STATIONS (LANDLORD)	2009		3,600	131	27.5	131		595	13
14	FIRE SPRINKLER SYSTEM (LANDLORD)	2009		2,500	91	27.5	91		413	14
15	PYROCHEM SYSTEM (LANDLORD)	2009		3,156	115	27.5	115		522	15
16	NURSE CALL LIGHT SYSTEM (LANDLORD)	2009		5,200	189	27.5	189		858	16
17	SPRINKLERS (LANDLORD)	2009		38,000	1,382	27.5	1,382		6,277	17
18	SIGNS (LANDLORD)	2009		4,781	174	27.5	174		790	18
19	ROOF (LANDLORD)	2009		11,000	399	27.5	399		1,813	19
20	CARPETING (LANDLORD)	2009		4,087	235	5	817	582	2,452	20
21	PAINTING (LANDLORD)	2009		53,725	3,094	5	10,745	7,651	32,236	21
22	CURTAINS (LANDLORD)	2009		19,732	1,137	5	3,946	2,809	11,838	22
23	BLINDS (LANDLORD)	2009		4,560	263	5	912	649	2,736	23
24	DRAPES (LANDLORD)	2010		6,677	385	5	1,335	950	3,071	24
25	DRAPES (LANDLORD)	2010		3,662		5	732	732	1,830	25
26	OUTDOOR LIGHTING (LANDLORD)	2010		7,380	492	15	492		1,722	26
27	DRAPES (LANDLORD)	2010		2,817	102	27.5	102		336	27
28	DRAIN LINE (LANDLORD)	2011		3,500	127	27.5	127		259	28
29	HOT WATER HEATER	2012		5,488	200	27.5	200		242	29
30	DRY PIPE VALVE FOR FIRE PROTECTION SYSTEM	2012		3,740	136	27.5	136		164	30
31	REPLACE 2 ROOF TOP HEATING AND A/C UNITS	2013		10,985	150	27.5	150		150	31
32	ALARM SMOKE DETECTORS	2013		3,995	54	27.5	54		54	32
33	NURSE CALL SYSTEM	2013		4,953	68	27.5	68		68	33
34	LIGHT FIXTURES	2013		2,678	37	27.5	37		37	34
35	VALVE FOR FIRE PROTECTION	2013		2,575	35	27.5	35		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

**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	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,144,278	\$ 115,741		\$ 129,114	\$ 13,373	\$ 685,658	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	\$ 144,867	\$ 5,776	\$ 14,487	\$ 8,711	10 YRS	\$ 65,622	71
72	Current Year Purchases	7,853	4,320	393	(3,927)		393	72
73	Fully Depreciated Assets							73
74	REL PARTY	650,000	39,384	65,000	25,616	10 YRS	357,500	74
75	TOTALS	\$ 802,720	\$ 49,480	\$ 79,880	\$ 30,400		\$ 423,515	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)	10	\$ 4,250	76
77	FACILITY	INFINITI G37 CONVERTIBLE	2010	64,255	1,775	6,426	4,651	10	25,704	77
78	FACILITY	2013 CADILLAC SRX	2013	67,525	11,160	3,376	(7,784)	10	3,376	78
79										79
80	TOTALS			\$ 140,280	\$ 13,914	\$ 10,652	\$ (3,262)		\$ 33,330	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)	\$ 4,814,054	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,135	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 219,646	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 40,511	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,142,503	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:				\$ 473,246			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ 473,246			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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 15,458 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			\$ _____	\$ 2,871	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ 2,871	21

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

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		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	39-3	hrs	\$		\$	100,783	\$		\$	100,783	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				118,435				118,435	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					118,781			118,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>lab,radiology,supplies</u>							10,324			10,324	12
13	Other (specify):											13
14	<b>TOTAL</b>			\$		\$	219,218	\$	129,105	\$	348,323	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 AND REHAB**

# **0049502**

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

Ending:

**12/31/2013**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2013**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 997	\$ 223,088	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000 )	1,567,606	1,567,606	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	235,868	235,868	6
7	Other Prepaid Expenses	6,500	16,500	7
8	Accounts Receivable (owners or related parties)	827,896	979,305	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 2,638,867</b>	<b>\$ 3,022,367</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		726,776	13
14	Buildings, at Historical Cost		2,907,102	14
15	Leasehold Improvements, at Historical Cost	4,517	237,176	15
16	Equipment, at Historical Cost	238,245	888,245	16
17	Accumulated Depreciation (book methods)	(165,655)	(1,535,688)	17
18	Deferred Charges		21,018	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 goodwill)		215,835	22
23	Other(specify): developmental costs	427,873	437,785	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 504,980</b>	<b>\$ 3,898,249</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 3,143,847</b>	<b>\$ 6,920,616</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 928,833	\$ 945,083	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	931,803	931,803	29
30	Accrued Salaries Payable	154,929	154,929	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,804	30,804	31
32	Accrued Real Estate Taxes(Sch.IX-B)	261,223	261,223	32
33	Accrued Interest Payable		15,450	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	mortgage payable- short term		249,118	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 2,307,592</b>	<b>\$ 2,588,410</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	40,989	40,989	39
40	Mortgage Payable		4,054,709	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>	<b>\$ 40,989</b>	<b>\$ 4,095,698</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 2,348,581</b>	<b>\$ 6,684,108</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 795,266</b>	<b>\$ 236,508</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 3,143,847</b>	<b>\$ 6,920,616</b>	<b>48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>659,252</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>		(2,967)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>656,285</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	273,981	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(135,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>138,981</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>795,266</b>	<b>24</b> *

\* 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	2
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,899,619	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,899,619	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		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			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,899,619	30

		1	2
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	945,138	31
32	Health Care	1,961,088	32
33	General Administration	1,322,673	33
<b>B. Capital Expense</b>			
34	Ownership	850,860	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	348,323	35
36	Provider Participation Fee	225,425	36
<b>D. Other Expenses (specify):</b>			
37	<u>OUT-OF-PERIOD EXPENSES</u>	(27,869)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,625,638	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	273,981	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 273,981	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 3,539,878	44
45	Private Pay - Net Inpatient Revenue	279,653	45
46	Medicare - Net Inpatient Revenue	1,995,038	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	85,050	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,899,619	49

**\*\*TAX RETURN PREPARED ON CASH BASIS**

\* 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 AND REHAB**

# **0049502**

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

Ending:

**12/31/2013**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,247	1,445	\$ 56,252	\$ 38.93	1
2	Assistant Director of Nursing	598	617	20,988	34.02	2
3	Registered Nurses	3,487	3,693	113,792	30.81	3
4	Licensed Practical Nurses	23,550	25,834	639,250	24.74	4
5	CNAs & Orderlies	57,137	61,408	639,406	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,463	3,619	163,136	45.08	8
9	Activity Director	1,775	2,030	33,653	16.58	9
10	Activity Assistants	4,590	4,970	49,876	10.04	10
11	Social Service Workers	1,951	2,086	44,951	21.55	11
12	Dietician	2,155	2,463	42,099	17.09	12
13	Food Service Supervisor					13
14	Head Cook	1,032	1,078	11,402	10.58	14
15	Cook Helpers/Assistants	10,322	11,808	127,525	10.80	15
16	Dishwashers	3,700	4,183	51,230	12.25	16
17	Maintenance Workers	2,418	2,540	42,315	16.66	17
18	Housekeepers	1,008	1,040	10,326	9.93	18
19	Laundry	470	502	4,725	9.41	19
20	Administrator	1,686	1,934	67,680	34.99	20
21	Assistant Administrator					21
22	Other Administrative	4,794	4,869	189,824	38.99	22
23	Office Manager					23
24	Clerical	10,160	10,653	137,721	12.93	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	75	77	2,012	26.13	31
32	Other Health C: CARE PLAN	2,362	2,427	63,789	26.28	32
33	Other(specify) WARD CLERK	157	162	4,246	26.21	33
34	TOTAL (lines 1 - 33)	138,137	149,438	\$ 2,516,198 *	\$ 16.84	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	\$ 7,052	1-3	35
36	Medical Director	O	10,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	4,208	10-3	38
39	Pharmacist Consultant	H	1,676	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		0	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)		\$ 23,536		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			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		\$ 67,680	Workers' Compensation Insurance	\$ 70,302	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	119,716	Advertising: Employee Recruitment	125	
HELEN LACEK	OTHER ADMIN	7.0	38,626	FICA Taxes	192,479	Health Care Worker Background Check	0	
JOEL ATKIN	OTHER ADMIN		48,060	Employee Health Insurance	86,896	(Indicate # of checks performed)		
ELISHA ATKIN	OTHER ADMIN		103,138	Employee Meals	9,910	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	7,366	MARKETING/ADV/PROMO	14,695	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	11,011	
				PENSION/PROFIT SHARING PLANS	11,302	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(14,695)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 257,504	TOTAL (agree to Schedule V, line 22, col.8)	\$ 497,971	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,136	
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
Yael Takin- Management Fees			\$ 12,073				Out-of-State Travel	\$
Donna Atkin- Management Fees			12,074					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 24,147				Seminar Expense	0
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense	( )
			\$				TOTAL (agree to Sch. V, line 24, col. 8)	\$
SEE SCHEDULE ATTACHED			77,335					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 77,335	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number MCALLISTER NURSING AND REHAB

# 0049502

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

## 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? \_\_\_\_\_ If YES, what is the capacity? NO
- (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? \_\_\_\_\_  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES \_\_\_\_\_ 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. \$ 225,425  
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. \$ 9,910 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.