

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0049502</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>MCALLISTER NURSING AND REHAB</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>18300 S. LAVERGNE</u> <u>TINLEY PARK</u> <u>60477</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>(708) 798-2272</u> Fax # <u>(708) 798-2298</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>ELI ATKIN</u></td></tr><tr><td>(Title) <u>ADMINISTRATOR</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>ELI ATKIN</u>	(Title) <u>ADMINISTRATOR</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)	Paid Preparer	(Date) _____	(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u>	(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <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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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>03/17/08</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number MCALLISTER NURSING AND REHAB

0049502 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	<u>79</u>	Skilled (SNF)	<u>79</u>	<u>28,835</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>32</u>	Intermediate (ICF)	<u>32</u>	<u>11,680</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>111</u>	TOTALS	<u>111</u>	<u>40,515</u>	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	<u>16,761</u>	<u>3,659</u>	<u>5,769</u>	<u>26,189</u>	8
9	SNF/PED					9
10	ICF	<u>8,544</u>	<u>466</u>	<u>130</u>	<u>9,140</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,305</u>	<u>4,125</u>	<u>5,899</u>	<u>35,329</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.20%

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

4,405

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number **MCALLISTER NURSING AND REHAB** # **0049502** Report Period Beginning: **01/01/2011** Ending: **12/31/2011**
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	208,151	10,733	1,204	220,088		220,088		220,088			1
2	Food Purchase		212,555		212,555	(10,348)	202,207	(1,612)	200,595			2
3	Housekeeping	956	10,955		11,911		11,911		11,911			3
4	Laundry	295	2,555	98,523	101,373		101,373		101,373			4
5	Heat and Other Utilities			103,867	103,867		103,867		103,867			5
6	Maintenance	34,423	13,272	192,271	239,966		239,966		239,966			6
7	Other (specify):*			12,590	12,590		12,590		12,590			7
8	TOTAL General Services	243,825	250,070	408,455	902,350	(10,348)	892,002	(1,612)	890,390			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,454,757	80,686	14,239	1,549,682		1,549,682		1,549,682			10
10a	Therapy	80,652	1,299		81,951		81,951		81,951			10a
11	Activities	97,473	4,611		102,084		102,084		102,084			11
12	Social Services	20,172		2,715	22,887		22,887		22,887			12
13	CNA Training											13
14	Program Transportation			280	280		280		280			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,653,054	86,596	24,434	1,764,084		1,764,084		1,764,084			16
	C. General Administration											
17	Administrative	234,843		305,479	540,322		540,322		540,322			17
18	Directors Fees											18
19	Professional Services			57,090	57,090		57,090		57,090			19
20	Dues, Fees, Subscriptions & Promotions			133,865	133,865		133,865	(122,007)	11,858			20
21	Clerical & General Office Expenses	163,054	20,321	247,137	430,512		430,512	(76,041)	354,471			21
22	Employee Benefits & Payroll Taxes			559,024	559,024	10,348	569,372	(70,755)	498,617			22
23	Inservice Training & Education			3,017	3,017		3,017		3,017			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,060	5,060		5,060		5,060			25
26	Insurance-Prop.Liab.Malpractice			176,484	176,484		176,484		176,484			26
27	Other (specify):*			60,000	60,000		60,000	(60,000)				27
28	TOTAL General Administration	397,897	20,321	1,547,156	1,965,374	10,348	1,975,722	(328,803)	1,646,919			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,294,776	356,987	1,980,045	4,631,808		4,631,808	(330,415)	4,301,393			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	1,204
		0
		1,204
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,523
	CONTRACTED LAUNDRY SERVICES	96,000
		98,523
5	HEAT & OTHER UTILITIES	
	GAS HEAT	32,346
	ELECTRICITY	53,917
	WATER	13,905
	CABLE TV - LOBBY	3,699
		0
		103,867
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,648
	PAINTING & DECORATING	1,350
	BUILDING REPAIRS	1,820
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	18,206
	ELEVATOR MAINTENANCE & REPAIR	1,440
	OUTSIDE LABOR	4,495
	EXTERMINATING SERVICE	3,975
	FIRE SERVICE	8,730
	CONTRACTED BUILDING MAINT.	144,607
		0
		0
		0
		192,271
7	OTHER	
	SCAVENGER	11,654
	SECURITY SERVICE	936
		0
		0
		12,590
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	1,710
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	3,291
	NURSING PROGRAM CONSULTANT	3,878
	DENTAL	5,360
		14,239
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,715
	SOCIAL WORKER XVIII B 45-2	0
		2,715
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	280
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	305,479
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,220
	ADMINISTRATIVE CONSULTANTS XIX C	1,500
	PROFESSIONAL FEES XIX C	39,370
		0
		57,090
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	4,182
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	13,041
	EMPLOYEE WANT ADS XIX F	2,071
	CONTRIBUTIONS VI 20 XIX F	101,784
	DUES & SUBSCRIPTIONS XIX F	4,597
	LICENSES & PERMITS XIX F	5,190
	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	3,000
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		133,865
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,029
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	195,864
	PENALTIES / OVERDRAFT CHARGES VI 18	2,177
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	44,067
	MESSENGER SERVICE	0
		0
		247,137

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	175,543
	UNEMPLOYMENT COMPENSATION XIX D	112,338
	WORKERS COMPENSATION INSURANC XIX D	65,455
	HOSPITALIZATION INSURANCE XIX D	115,200
	EMPLOYEE BENEFITS - OTHER XIX D	4,253
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	70,755
	PENSION/PROFIT SHARING PLANS XIX D	15,480
	CHICAGO HEAD TAX XIX D	0
		0
		559,024
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,017
		3,017
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	5,060
		5,060
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	176,484
		176,484
27	OTHER	
	BAD DEBTS VI 24	60,000
		60,000

GRAND TOTAL COLUMN 3 OTHER

1,980,045

MCALLISTER NURSING AND REHAB
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	212,555
LESS SALES TAX	<u>(1,612)</u>
NET FOOD	210,943
TOTAL PATIENT CENSUS	35,329
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	105,987
ADD # EMPLOYEE MEALS/DAY	15
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	5,475
PATIENT MEALS	105,987
ADD EMPLOYEE MEALS	<u>5,475</u>
TOTAL MEALS/YEAR	111,462
NET FOOD	210,943
DIVIDE TOTAL MEALS/YEAR	<u>111,462</u>
COST PER MEAL	1.89
TIME EMPLOYEE MEALS	<u>5,475</u>
EMPLOYEE MEAL RECLASSIFICATION	10,348
	=====

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,926	27,926		27,926	218,348	246,274			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,653	59,653		59,653	236,808	296,461			32
33	Real Estate Taxes			247,282	247,282		247,282		247,282			33
34	Rent-Facility & Grounds			324,706	324,706		324,706	(324,706)				34
35	Rent-Equipment & Vehicles			22,210	22,210		22,210		22,210			35
36	Other (specify):*											36
37	TOTAL Ownership			681,777	681,777		681,777	130,450	812,227			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,112	196,774	338,886		338,886		338,886			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,773	60,773		60,773		60,773			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		142,112	257,547	399,659		399,659		399,659			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,294,776	499,099	2,919,369	5,713,244		5,713,244	(199,965)	5,513,279			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	20,970	30		9
10	Interest and Other Investment Income	(183)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,612)	2		13
14	Non-Care Related Interest	(25,397)	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	(2,177)	21		18
19	Entertainment	(4,182)	20		19
20	Contributions	(104,784)	20		20
21	Owner or Key-Man Insurance	(70,755)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(13,041)	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	(73,864)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (335,025)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	135,060		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 135,060		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (199,965)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS
MCALLISTER NURSING AND REHAB

Report Period Beginning: ID# 0049502
Ending: 01/01/2011
12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	O/S CLERICAL	(73,864)	21	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	(73,864)		49

Summary B

12/31/2011

[illegible]

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			McAllister		
Donna Atkin	44			Property L.L.C.	Tinley Park	Real Estate
Jay OrLinsky	5					
Helen Lacek	7					

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.

X 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	\$ 324,706	MC ALLISTER PROPERTY, LLC		\$	(324,706)	1
2	V	30	DEPRECIATION				197,378	197,378	2
3	V	32	INTEREST				252,205	252,205	3
4	V	32	AMORT LOAN COSTS				10,183	10,183	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			\$ 324,706			\$ 459,766	\$ * 135,060	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: 01/01/2011 Ending: 12/31/2011

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	Administrator	Administration			40	80.00	SALARY	\$ 100,277	17-1	1
2			Purchases								2
3	JOEL ATKIN	Administrator	Administration			8	45.00	SALARY	50,118	17-1	3
4											4
5	HELEN LACEK	MEMBER	ADMIN.	7.00				SALARY	2,121	17-1	5
6											6
7											7
8	Yael Atkin	MEMBER	ADMIN.	44.00		5	50.00	mgmt	152,740	17-3	8
9								o/s bkkpng	61,000	21-3	9
10	DONNA ATKIN	MEMBER	ADMIN.	44.00		25	93.00	mgmt	152,739	17-3	10
11								o/s bkkpng	61,000	21-3	11
12											12
13								TOTAL	\$ 579,995		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: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization McALLISTER PROPERTY, LLC
Street Address 18300 S LAVERGNE
City / State / Zip Code TINLEY PARK, ILL 60477
Phone Number (708)798-2272
Fax Number (708)798-2298

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	\$ 197,378	\$	1	\$ 197,378	1
2	32	INTEREST	DIRECT COSTS	1	1	252,205		1	252,205	2
3	32	AMORT LOAN COSTS	DIRECT COSTS	1	1	10,183		1	10,183	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					\$ 459,766	\$		\$ 459,766	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	MC ALLISTER PROPERTY, LLC						\$					\$	1	
2	FIRST BANK		X	MORTGAGE		5/24/11		4,600,000	4,705,951	05/24/13			239,987	2
3	1ST EQUITY (REL PARTY)		X	WORKING CAPITAL		3/19/08		601,800			6.5000		12,218	3
4	LOAN COSTS			AMORTIZE OVER LIFE OF LOAN					15,806				10,183	4
5	INSURANCE												655	5
	Working Capital													
6	FIRST MERIT BANK		X	WORKING CAPITAL	INT ONLY	3/17/08		600,000	716,055	REVOLV	5.0000		32,223	6
7														7
8	INFINITY FINANCIAL		X	AUTO		1/10/10		59,255	12,761	5/31/15	2.9000		1,378	8
9	TOTAL Facility Related					\$1,063.39		\$ 5,861,055	\$ 5,450,573				\$ 296,644	9
	B. Non-Facility Related*													
10	BED TAX												6,078	10
11	REAL ESTATE TAXES												7,663	11
12	NATIONAL GOV'T SERVICES												336	12
13	JACK ATKIN	X											11,320	13
14	TOTAL Non-Facility Related							\$					\$ 25,397	14
15	TOTALS (line 9+line14)							\$ 5,861,055	\$ 5,450,573				\$ 322,041	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 2010 report.			\$ 317,526	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.)			\$ 247,404	2
3. Under or (over) accrual (line 2 minus line 1).			\$ (70,122)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 317,404	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.			\$ 247,282	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006		8	
	2007	231,660	9	
	2008	287,500	10	
	2009	247,527	11	
	2010	247,404	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.				
	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2010	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION \$			16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>MCALLISTER NURSING AND REHAB</u>	COUNTY	<u>COOK</u>
---------------	-------------------------------------	--------	-------------

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 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>28-33-403-043-0000</u>	<u>NURSING HOME</u>	\$ <u>218,131.22</u>	\$ <u>218,131.22</u>
2. <u>28-33-403-007-0000</u>	<u>NURSING HOME</u>	\$ <u>25,052.29</u>	\$ <u>25,052.29</u>
3. <u>28-33-403-008-0000</u>	<u>NURSING HOME</u>	\$ <u>4,220.73</u>	\$ <u>4,220.73</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u>247,404.24</u>	\$ <u>247,404.24</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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	NURSING HOME		2008	\$ 726,776	1
2					2
3	TOTALS			\$ 726,776	3

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			2008		\$ 2,907,102	\$ 105,713	27.5	\$ 105,713	\$	\$ 400,828	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOORS			2008	4,517	164	27.5	164		636	9
10	COVE BASE FLOORING (LANDLORD)			2009	2,520	92	27.5	92		234	10
11	DOORS (LANDLORD)			2009	5,131	186	27.5	186		473	11
12	HANDRAILS (LANDLORD)			2009	16,217	590	27.5	590		1,499	12
13	2 NURSE STATIONS (LANDLORD)			2009	3,600	131	27.5	131		333	13
14	FIRE SPRINKLER SYSTEM (LANDLORD)			2009	2,500	91	27.5	91		231	14
15	PYROCHEM SYSTEM (LANDLORD)			2009	3,156	115	27.5	115		292	15
16	NURSE CALL LIGHT SYSTEM (LANDLORD)			2009	5,200	189	27.5	189		480	16
17	SPRINKLERS (LANDLORD)			2009	38,000	1,382	27.5	1,382		3,513	17
18	SIGNS (LANDLORD)			2009	4,781	174	27.5	174		442	18
19	ROOF (LANDLORD)			2009	11,000	399	27.5	399		1,015	19
20	CARPETING (LANDLORD)			2009	4,087	392	5	654	262	818	20
21	PAINTING (LANDLORD)			2009	53,725	5,158	5	8,596	3,438	10,746	21
22	CURTAINS (LANDLORD)			2009	19,732	1,894	5	3,157	1,263	3,946	22
23	BLINDS (LANDLORD)			2009	4,560	438	5	730	292	912	23
24	DRAPES (LANDLORD)			2010	6,677	1,068	5	4,007	2,939	401	24
25	DRAPES (LANDLORD)			2010	3,662		5	3,662	3,662	366	25
26	OUTDOOR LIGHTING (LANDLORD)			2010	7,380	492	15	492		738	26
27	DRAPES (LANDLORD)			2010	2,817	102	27.5	102	102	132	27
28	DRAIN LINE (LANDLORD)			2011	3,500	5	27.5	5		5	28
29											29
30											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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 3,109,864	\$ 118,775		\$ 130,631	\$ 11,958	\$ 428,040	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	\$ 214,328	\$ 11,203	\$ 42,866	\$ 31,663	10	\$ 121,218	71
72	Current Year Purchases	10,027	10,027	501	(9,526)	10	501	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		78,767	65,000	(13,767)			74
75	TOTALS	\$ 224,355	\$ 99,997	\$ 108,367	\$ 8,370		\$ 121,719	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	\$ 1,632	\$ 850	\$ (782)	5	\$ 2,550
77	FACILITY	INFINITI G37 CONVERTIBLE	2010	64,255	4,900	6,426	1,526	5	12,852
78									
79									
80	TOTALS			\$ 72,755	\$ 6,532	\$ 7,276	\$ 744		\$ 15,402

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 4,133,750
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 225,304
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 246,274
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 20,970
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 565,161

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

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: \$22,210
- 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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		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)	\$			

(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.

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	

(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.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 68,185	\$		\$ 68,185	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			128,589			128,589	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				119,941		119,941	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LABORATORY Other (specify): MEDICAL SUPPLIES	39-3 39-2					11,198 10,973		11,198 10,973	13
14	TOTAL			\$		\$ 196,774	\$ 142,112		\$ 338,886	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.

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	\$ 47,694	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (74,803))	918,686		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	278,606		6
7	Other Prepaid Expenses	8,835		7
8	Accounts Receivable (owners or related parties)	1,133,606		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,387,427	\$	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	255,150		16
17	Accumulated Depreciation (book methods)	(188,514)		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 (spe develop. Cost	81,506		22
23	Other(specify): due from mcallister properties	197,110		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 349,769	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,737,196	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,138,679	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,970		28
29	Short-Term Notes Payable	716,055		29
30	Accrued Salaries Payable	136,548		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,479		31
32	Accrued Real Estate Taxes(Sch.IX-B)	317,404		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Infiniti Financial Services</u>	12,761		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,386,896	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	28,574		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)	\$ 28,574	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,415,470	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 321,726	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,737,196	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 476,076	1
2	Restatements (describe):		2
3	Post Closing Adjustment	(8,020)	3
4	ROUNDING	(2)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 468,054	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	400,045	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	(546,373)	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)	\$ (146,328)	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)	\$ 321,726	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,945,430	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,945,430	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	163,246	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 163,246	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***	183	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 183	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)	\$ 6,108,859	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	902,350	31
32	Health Care	1,764,084	32
33	General Administration	1,965,374	33
	B. Capital Expense		
34	Ownership	681,777	34
	C. Ancillary Expense		
35	Special Cost Centers	338,886	35
36	Provider Participation Fee	60,773	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(4,430)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,708,814	40
41	Income before Income Taxes (line 30 minus line 40)**	400,045	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 400,045	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.
tax return not filed as of c/r filing date

*** 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.

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	1,709	1,923	\$ 76,018	\$ 39.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,404	2,422	70,385	29.06	3
4	Licensed Practical Nurses	27,790	29,050	677,592	23.33	4
5	CNAs & Orderlies	53,288	55,121	555,528	10.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,212	2,320	80,652	34.76	8
9	Activity Director	1,668	1,767	29,204	16.53	9
10	Activity Assistants	6,476	6,897	68,269	9.90	10
11	Social Service Workers	1,097	1,118	20,172	18.04	11
12	Dietician					12
13	Food Service Supervisor	2,380	2,499	43,544	17.42	13
14	Head Cook	1,840	1,933	16,982	8.79	14
15	Cook Helpers/Assistants	13,202	14,252	147,625	10.36	15
16	Dishwashers					16
17	Maintenance Workers	1,899	1,959	34,423	17.57	17
18	Housekeepers	56	56	956	17.07	18
19	Laundry	18	18	295	16.39	19
20	Administrator	4,315	4,331	152,516	35.21	20
21	Assistant Administrator	2,071	2,100	82,327	39.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,396	11,061	163,054	14.74	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	1,862	1,910	52,302	27.38	31
32	Other Health C: Qualified mental r	507	507	22,932	45.23	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,190	141,244	\$ 2,294,776 *	\$ 16.25	34

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	3,291	10-3	38
39	Pharmacist Consultant	H	1,710	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	2,715	12-3	45
46	Other(specify) Nursing Program	S	3,878	10-3	46
47	Dental		5,360	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,154		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		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberMCALLISTER NURSING AND REHAB# 0049502Report Period Beginning:01/01/2011Ending:12/31/2011Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ATKIN,ELISHA	ADMINISTRATOR		\$ 100,277
ATKIN,JOEL	ADMIMISTRATIVE		50,118
LACEK,HELEN	ADMIMISTRATIVE	7	2,121
WAGNER,GERALDINE	ASST ADMIN		82,327
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 234,843

B. Administrative - Other

Description	Amount
YEAL ATKIN MANAGEMENT FEES	\$ 152,740
DONNA ATKIN MANAGEMENT FEES	152,739
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		\$
SEE SCHEDULE ATTACHED		57,090
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 57,090

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 65,455
Unemployment Compensation Insurance	112,338
FICA Taxes	175,543
Employee Health Insurance	115,200
Employee Meals	10,348
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,253
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	15,480
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	70,755
INSURANCE - EXECUTIVE LIFE VI 21	(70,755)
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	2,071
Health Care Worker Background Check (Indicate # of checks performed)	0
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	104,784
MARKETING/ADV/PROMO	17,223
LICENSES/DUES/SUBSCRIPTIONS	9,787
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(104,784)
Less: Public Relations Expense	(4,182)
Non-allowable advertising	(13,041)
Yellow page advertising (	0)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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?
If YES, give association name and amount.

NO
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO
- (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?
What was the average life used for new equipment added during this period?

YES
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

0
10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
- (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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 60,773
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

- (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?
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.

NO
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
\$
Has any meal income been offset against related costs?
Indicate the amount. \$

10,348
N/A
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

NO
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?
Attach invoices and a summary of services for all architect and appraisal fees.

YES