

		FOR BHF USE					

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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>050880</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Parker Rehabilitation and Nursing Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/11</u> to <u>12/31/11</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>516 West Frech Street</u> <u>Streator</u> <u>61364</u>			
Number City Zip Code			
County: <u>Lasalle</u>			
Telephone Number: <u>(708) 236-0000</u> Fax # <u>(708) 236-0001</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>5/1/98</u>			
Type of Ownership:		Officer or Administrator of Provider	
☐ VOLUNTARY,NON-PROFIT		(Signed) _____ (Date) _____	
☐ Charitable Corp.		(Type or Print Name) <u>Joseph Blisko</u>	
☐ Trust		(Title) <u>Manager</u>	
IRS Exemption Code _____		(Signed) <u>See Accountants' Compilation Report Attached</u> (Date) _____	
		Paid Preparer	
		(Print Name <u>Dan Gaafar</u> and Title) <u>Partner</u>	
		(Firm Name <u>Bradley Associates</u> & Address) <u>201 S. Capitol Ave., Indianapolis, IN 46225</u>	
		(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>	
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE	
Name: <u>Dan Gaafar</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES	
Telephone Number: <u>(317) 237-5500</u>		201 S. Grand Avenue East	
Email Address: _____		Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parker Rehabilitation and Nursing Center

050880 Report Period Beginning: 1/1/11 Ending: 12/31/11

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>102</u>	Skilled (SNF)	<u>102</u>	<u>37,230</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	TOTALS	<u>102</u>	<u>37,230</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>8,714</u>	<u>1,127</u>	<u>2,043</u>	<u>11,884</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,714</u>	<u>1,127</u>	<u>2,043</u>	<u>11,884</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 31.92%

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)
N/A

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 5/1/98

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 5/1/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 100 and days of care provided 1,994

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

STATE OF ILLINOIS												
Facility Name & ID Number		Parker Rehabilitation and Nursing Center				#	050880	Report Period Beginning:		1/1/11	Ending:	Page 3 12/31/11
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	113,528	9,899	4,098	127,525		127,525	(35)	127,490			1
2	Food Purchase		72,420		72,420		72,420		72,420			2
3	Housekeeping	54,912	7,383		62,295		62,295		62,295			3
4	Laundry	33,664	5,815		39,479		39,479		39,479			4
5	Heat and Other Utilities			83,394	83,394		83,394	934	84,328			5
6	Maintenance	39,332	10,438	15,524	65,294		65,294	3,549	68,843			6
7	Other (specify):*											7
8	TOTAL General Services	241,436	105,955	103,016	450,407		450,407	4,448	454,855			8
	B. Health Care and Programs											
9	Medical Director			4,885	4,885		4,885		4,885			9
10	Nursing and Medical Records	620,154	59,599	41,073	720,826		720,826	2,514	723,340			10
10a	Therapy			271,970	271,970		271,970		271,970			10a
11	Activities	18,814	18,388		37,202		37,202		37,202			11
12	Social Services	26,527		2,958	29,485		29,485		29,485			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			2,222	2,222		2,222		2,222			15
16	TOTAL Health Care and Programs	665,495	77,987	323,108	1,066,590		1,066,590	2,514	1,069,104			16
	C. General Administration											
17	Administrative	66,171			66,171		66,171		66,171			17
18	Directors Fees											18
19	Professional Services			25,035	25,035		25,035	33,052	58,087			19
20	Dues, Fees, Subscriptions & Promotions			3,744	3,744		3,744	139	3,883			20
21	Clerical & General Office Expenses	52,962	28,134	13,360	94,456		94,456	(4,123)	90,333			21
22	Employee Benefits & Payroll Taxes			184,132	184,132		184,132	1,945	186,077			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,344	3,344		3,344	6,105	9,449			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			35,826	35,826		35,826	1,026	36,852			26
27	Other (specify):*											27
28	TOTAL General Administration	119,133	28,134	265,441	412,708		412,708	38,144	450,852			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,026,064	212,076	691,565	1,929,705		1,929,705	45,106	1,974,811			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			28,326	28,326		28,326	(18,664)	9,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,000	1,000		1,000	(976)	24			32
33	Real Estate Taxes			62,700	62,700		62,700		62,700			33
34	Rent-Facility & Grounds			216,000	216,000		216,000	5,431	221,431			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			308,026	308,026		308,026	(14,209)	293,817			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,243		58,243		58,243		58,243			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		58,243	55,845	114,088		114,088		114,088			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,026,064	270,319	1,055,436	2,351,819		2,351,819	30,897	2,382,716			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(18,791)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9,100)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,726)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,652)		\$	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)	68,549	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 68,549		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 30,897		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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: ID# 050880

Ending: 1/1/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (768)	6	1
2	PROMOTIONS	(7,958)	21	2
3	RELATED PARTY INTEREST EXPENSE	(1,000)	32	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,726)		49

Summary A

12/31/11

[illegible]

Summary B

Facility Name & ID Number	Parker Rehabilitation and Nursing Center	#	050880	Report Period Beginning:	1/1/11	Ending:	12/31/11
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[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
Joseph Blisko	100	Berkeley Nursing & Rehab	Oak Park	Senior Healthcare	Skokie	Management Co.
				JB Health Care	Skokie	Management Co.

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	21	ADMIN WAGES	\$	SENIOR HEALTHCARE MANAGEMENT		\$ 8,900	\$ 8,900	1
2	V	5	UTILITIES		SENIOR HEALTHCARE MANAGEMENT		280	280	2
3	V	19	PROFESSIONAL FEES		SENIOR HEALTHCARE MANAGEMENT		1,802	1,802	3
4	V	20	LICENSE & FEES		SENIOR HEALTHCARE MANAGEMENT		14	14	4
5	V	21	OTHER ADMIN EXPENSE		SENIOR HEALTHCARE MANAGEMENT		156	156	5
6	V	22	FRINGE BENEFITS		SENIOR HEALTHCARE MANAGEMENT		1,945	1,945	6
7	V	24	TRAVEL		SENIOR HEALTHCARE MANAGEMENT		496	496	7
8	V	26	INSURANCE		SENIOR HEALTHCARE MANAGEMENT		31	31	8
9	V	30	DEPRECIATION		SENIOR HEALTHCARE MANAGEMENT		127	127	9
10	V	32	INTEREST		SENIOR HEALTHCARE MANAGEMENT		24	24	10
11	V	34	RENT		SENIOR HEALTHCARE MANAGEMENT		431	431	11
12	V	6	REPAIRS & MAINTENANCE		SENIOR HEALTHCARE MANAGEMENT		1	1	12
13	V	21	OFFICE SUPPLIES		SENIOR HEALTHCARE MANAGEMENT		631	631	13
14	Total			\$			\$ 14,838	\$ * 14,838	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	5	TELEPHONE	\$	JB HEALTHCARE LLC		\$ 654	\$ 654	15
16	V	6	REPAIRS & MAINTENANCE		JB HEALTHCARE LLC		4,316	4,316	16
17	V	19	PROFESSIONAL FEES	(30,000)	JB HEALTHCARE LLC		1,250	31,250	17
18	V	20	DUES & SUBSCRIPTIONS		JB HEALTHCARE LLC		125	125	18
19	V	21	OFFICE EXPENSE		JB HEALTHCARE LLC		452	452	19
20	V	24	TRAVEL		JB HEALTHCARE LLC		5,609	5,609	20
21	V	26	INSURANCE		JB HEALTHCARE LLC		995	995	21
22	V	34	RENT		JB HEALTHCARE LLC		5,000	5,000	22
23	V	21	OFFICE SUPPLIES		JB HEALTHCARE LLC		2,796	2,796	23
24	V								24
25	V	10	NURSING WAGES		SENIOR HEALTHCARE MANAGEMENT		2,514	2,514	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ (30,000)			\$ 23,711	\$ * 53,711	39

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

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Parker Rehabilitation and Nursing Center # 050880 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	78,321	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.)				\$	35,170	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(43,151)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	105,851	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.				\$	62,700	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006		8			
	2007		9			
	2008		10			
	2009	36,264	11			
	2010	35,170	12			

	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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Parker Rehabilitation and Nursing Center</u>	COUNTY	<u>Lasalle</u>
FACILITY IDPH LICENSE NUMBER	<u>050880</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Dan Gaafar</u>		
TELEPHONE	(317) 237-5500	FAX #:	(317) 237-5503

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.

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:

20,000

B. General Construction Type:

Exterior

BRICK

Frame

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parker Rehabilitation and Nursing Center

050880

Report Period Beginning:

1/1/11

Ending:

12/31/11

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	102				\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	SIGNS		4/30/2010		680	17	39	17		30
10	ROOF		4/7/2010		30,000	769	39	769		1,314
11	SHOWER TILES		10/19/2010		1,000	26	39	26		31
12	SIGNS		4/6/2010		684	18	39	18		30
13	EXHAUST FAN AND HOOD		5/28/2010		1,253	32	39	32		50
14	DRYWALL, WINDOWS, INSULATION, CEILING TILES		4/15/2010		6,300	162	39	162		249
15	PAINTING, VINYL COVE BASE, REMOVE WALL COVERING		5/3/2010		3,868	99	39	99		153
16	INSTALL BATHROOM ACCESSORIES, PATIO, AND WALL		5/13/2010		127,000	3,256	39	3,256		5,020
17	INSTALLATION OF DATA LINES AND PHONES		6/11/2010		1,750	45	39	45		69
18	BOILER		11/10/2010		5,000	1,225	39	128	(1,097)	1,940
19	TERMITE AND MOLD TREATMENT		5/14/2010		6,749	1,653	39	173	(1,480)	2,617
20	MOLD REMOVAL		4/3/2010		6,041	1,479	39	155	(1,324)	2,342
21	SPRINKLER SYSTEM		9/29/2010		2,538	622	39	65	(557)	985
22	TERMITE TREATMENT		4/9/2010		6,500	1,592	39	167	(1,425)	2,520
23	MOLD TESTING		4/2/2010		1,434	351	39	37	(314)	556
24	FREEZER		6/20/2011		4,994	4,994	39	64	(4,930)	4,994
25										25
26										26
27										27
28										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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$205,791	\$16,340		\$5,213	\$(11,127)	\$22,900	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$18,797	\$5,111	\$3,761	\$(1,350)	5	\$7,960	71
72	Current Year Purchases	7,002	7,002	688	(6,314)	5	7,002	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$25,799	\$12,113	\$4,449	\$(7,664)		\$14,962	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$231,590	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$28,453	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$9,662	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(18,791)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$37,862	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: CAMELOT TERRACE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:	1999	102	4/1/10	\$ 216,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		102		\$ 216,000			7

**

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

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

9. Option to Buy:

☐ YES

☒ NO

 Terms: *

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

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO
16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 4/1/10

Ending 3/31/30

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

	Fiscal Year Ending	Annual Rent
12.	12/31/12	\$ 408,000
13.	12/31/13	\$ 420,000
14.	12/31/14	\$ 432,000

* 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

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	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	10a-3	hrs	\$		\$ 86,083	\$		\$ 86,083	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			67,073			67,073	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			118,814			118,814	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				54,597		54,597	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab & X-ray	39-2					3,645		3,645	13
14	TOTAL			\$		\$ 271,970	\$ 58,242		\$ 330,212	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 128,843	\$ 128,843	1
2	Cash-Patient Deposits	(7,962)	(7,962)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	502,974	502,974	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,900	16,900	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 640,755	\$ 640,755	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	200,796	200,796	15
16	Equipment, at Historical Cost	30,792	30,792	16
17	Accumulated Depreciation (book methods)	(37,863)	(37,863)	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 Security Deposit	1,955	1,955	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 195,680	\$ 195,680	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 836,435	\$ 836,435	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 412,710	\$ 412,710	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,429	66,429	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 479,139	\$ 479,139	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 479,139	\$ 479,139	46
47	TOTAL EQUITY(page 18, line 24)	\$ 357,296	\$ 357,296	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 836,435	\$ 836,435	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (346,028)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (346,028)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(276,675)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	979,999	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 703,324	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)	\$ 357,296	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,856,689	1
2	Discounts and Allowances for all Levels	111,274	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,967,963	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	87,644	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 87,644	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	17,594	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	830	19
20	Radiology and X-Ray	345	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,769	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	768	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 768	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,075,144	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	450,407	31
32	Health Care	1,066,590	32
33	General Administration	412,708	33
	B. Capital Expense		
34	Ownership	308,026	34
	C. Ancillary Expense		
35	Special Cost Centers	58,243	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,351,819	40
41	Income before Income Taxes (line 30 minus line 40)**	(276,675)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (276,675)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

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

****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	1,449	1,495	\$ 44,952	\$ 30.07	1
2	Assistant Director of Nursing	1,112	1,135	24,322	21.43	2
3	Registered Nurses	3,860	3,913	101,767	26.01	3
4	Licensed Practical Nurses	7,482	8,000	173,971	21.75	4
5	CNAs & Orderlies	23,955	25,764	273,039	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,923	2,043	18,814	9.21	9
10	Activity Assistants					10
11	Social Service Workers	1,963	2,091	26,527	12.69	11
12	Dietician	11,389	11,915	113,528	9.53	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,935	2,233	39,332	17.61	17
18	Housekeepers	5,579	5,854	54,912	9.38	18
19	Laundry	3,462	3,976	33,664	8.47	19
20	Administrator	1,901	2,048	66,171	32.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,196	5,555	52,962	9.53	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	207	207	2,103	10.16	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,413	76,229	\$ 1,026,064 *	\$ 13.46	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	117	\$ 4,098	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	70	2,451	10-3	38
39	Pharmacist Consultant	44	2,222	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	85	2,958	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	316	\$ 11,729		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberParker Rehabilitation and Nursing Center# 050880Report Period Beginning: 1/1/11Ending: 12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sarah Simons	Admin		\$ 3,685
Angela Melbrech	Admin		42,634
Cindy Duncan	Admin		19,852
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,171

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FOLEY & LARDNER	LEGAL SERVICES	\$ 23,750
MYER MAGENCE	LEGAL SERVICES	125
SENIOR HEALTHCARE	ACCOUNTING FEES	31,160
JB HEALTH CARE LLC	MANAGEMENT FEES	(30,000)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 25,035

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 26,919	
Unemployment Compensation Insurance	57,092	
FICA Taxes	77,558	
Employee Health Insurance	9,217	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
UNIFORM EXPENSE	(23)	
EMPLOYEE EXPENSE	15,270	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 186,033

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		
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks		
Illinois Dept of Health Renewal	2,662	
LaSalle Co Health Renewal	170	
Sate Fire Marshall	300	
Other Licenses and Dues	751	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,883

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
MILEAGE	5,269
PARKING	1,054
Seminar Expense	
Meals	3,126
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 9,449

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2) Are there any dues to nursing home associations included on the cost report?

NO

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

5 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$6,787

Line10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

X

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.

\$55,845

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?

N/A

(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?

N/A

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.

\$NONE

Has any meal income been offset against related costs?

NO

Indicate the amount. \$0

(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?

100%

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

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. \$

(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 out of Schedule V?

N/A

(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.

SEE ACCOUNTANTS' COMPILATION REPORT