

		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>0048942</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>SKOKIE MEADOWS NURSING CENTER #2</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>4600 GOLF ROAD</u> <u>SKOKIE</u> <u>60076</u>																																																			
Number City Zip Code																																																			
County: <u>COOK</u>																																																			
Telephone Number: <u>(847) 679-1157</u> Fax # <u>(847) 626-0432</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>MARK APPEL</u></td></tr><tr><td>(Title) <u>OWNER</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MARK APPEL</u>	(Title) <u>OWNER</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)																																											
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	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)																																																		
Date of Initial License for Current Owners: <u>11/01/07</u>		<table><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <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><tr><td>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</td></tr></table>		Paid Preparer	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	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																																											
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Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____																																																			

Facility Name & ID Number SKOKIE MEADOWS NURSING CENTER #2

0048942 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>111</u>	Skilled (SNF)	<u>111</u>	<u>40,515</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>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					8
9	SNF/PED					9
10	ICF	<u>27,242</u>	<u>351</u>	<u>8,646</u>	<u>36,239</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,242	351	8,646	36,239	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.45%

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

X

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

YES

☐

NO

X

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

Date started

11/01/07

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

YES

☒

Date

11/01/07

NO

☐

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

YES

☐

NO

X

If YES, enter number of beds certified _____ and days of care provided _____

0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

X

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 **SKOKIE MEADOWS NURSING CENTER #** # **0048942** 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	150,769	10,216	8,640	169,625		169,625		169,625			1
2	Food Purchase		192,801		192,801	(12,118)	180,683		180,683			2
3	Housekeeping	162,352	25,535		187,887		187,887		187,887			3
4	Laundry		14,226		14,226		14,226		14,226			4
5	Heat and Other Utilities			93,741	93,741		93,741		93,741			5
6	Maintenance	25,564	13,674	32,728	71,966		71,966		71,966			6
7	Other (specify):*			6,639	6,639		6,639		6,639			7
8	TOTAL General Services	338,685	256,452	141,748	736,885	(12,118)	724,767		724,767			8
	B. Health Care and Programs											
9	Medical Director			12,560	12,560		12,560		12,560			9
10	Nursing and Medical Records	1,069,817	122,359	58,163	1,250,339		1,250,339		1,250,339			10
10a	Therapy											10a
11	Activities	74,491	15,179	493	90,163		90,163		90,163			11
12	Social Services	164,372		493	164,865		164,865		164,865			12
13	CNA Training											13
14	Program Transportation			368	368		368		368			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,308,680	137,538	72,077	1,518,295		1,518,295		1,518,295			16
	C. General Administration											
17	Administrative	75,876		312,000	387,876		387,876		387,876			17
18	Directors Fees											18
19	Professional Services			54,522	54,522		54,522		54,522			19
20	Dues, Fees, Subscriptions & Promotions			41,824	41,824		41,824	(22,198)	19,626			20
21	Clerical & General Office Expenses	29,973	10,628	23,702	64,303		64,303		64,303			21
22	Employee Benefits & Payroll Taxes			332,796	332,796	12,118	344,914		344,914			22
23	Inservice Training & Education			533	533		533		533			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			8,197	8,197		8,197		8,197			25
26	Insurance-Prop.Liab.Malpractice			65,552	65,552		65,552		65,552			26
27	Other (specify):*											27
28	TOTAL General Administration	105,849	10,628	839,126	955,603	12,118	967,721	(22,198)	945,523			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,753,214	404,618	1,052,951	3,210,783		3,210,783	(22,198)	3,188,585			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	7,776
	REPAIRS & MAINTENANCE	864
		0
		8,640
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	33,942
	ELECTRICITY	43,770
	WATER	13,759
	CABLE TV - LOBBY	2,270
		0
		93,741
6	MAINTENANCE	
	GROUPS MAINTENANCE	2,761
	PAINTING & DECORATING	4,686
	BUILDING REPAIRS	1,310
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,867
	ELEVATOR MAINTENANCE & REPAIR	2,645
	OUTSIDE LABOR	400
	EXTERMINATING SERVICE	705
	FIRE SERVICE	9,956
	CONTRACTED BUILDING MAINT.	3,398
		0
		0
		0
		32,728
7	OTHER	
	SCAVENGER	6,639
	SECURITY SERVICE	0
		0
		0
		6,639
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,560
		12,560

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	5,101
	PURCHASED SERVICES	17,961
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,512
	PHARMACY CONSULTANT XVIII B 39-2	6,589
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	24,000
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		58,163
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	493
		0
		493
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	493
	SOCIAL WORKER XVIII B 45-2	
		493
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	368
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	312,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,572
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	43,950
		0
		54,522
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	19,007
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	3,191
	DUES & SUBSCRIPTIONS XIX F	14,251
	LICENSES & PERMITS XIX F	5,375
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		41,824
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	23,697
	MESSENGER SERVICE	0
		0
		23,702

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	133,105
	UNEMPLOYMENT COMPENSATION XIX D	8,538
	WORKERS COMPENSATION INSURANC XIX D	24,291
	HOSPITALIZATION INSURANCE XIX D	136,780
	EMPLOYEE BENEFITS - OTHER XIX D	6,638
	EMPLOYEE PHYSICAL EXAMS XIX D	1,225
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	22,219
	CHICAGO HEAD TAX XIX D	0
		0
		332,796
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	533
		533
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,197
		8,197
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	65,552
		65,552
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,052,951

SKOKIE MEADOWS NURSING CENTER #2
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	192,801	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO EN
NET FOOD	192,801	
TOTAL PATIENT CENSUS	36,239	
TIME 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	108,717	
ADD # EMPLOYEE MEALS/DAY	20	
TIME # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	7,300	
PATIENT MEALS	108,717	
ADD EMPLOYEE MEALS	<u>7,300</u>	
TOTAL MEALS/YEAR	116,017	
NET FOOD	192,801	
DIVIDE TOTAL MEALS/YEAR	<u>116,017</u>	
COST PER MEAL	1.66	
TIME EMPLOYEE MEALS	<u>7,300</u>	
EMPLOYEE MEAL RECLASSIFICATION	12,118	
	=====	

INTER SALES TAX ON PAGE 5??

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			88,979	88,979		88,979	23,083	112,062			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,080	1,080		1,080	388,482	389,562			32
33	Real Estate Taxes			196,788	196,788		196,788		196,788			33
34	Rent-Facility & Grounds			903,121	903,121		903,121	(903,121)				34
35	Rent-Equipment & Vehicles			8,381	8,381		8,381		8,381			35
36	Other (specify):*							32,535	32,535			36
37	TOTAL Ownership			1,198,349	1,198,349		1,198,349	(459,021)	739,328			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,863	60,863		60,863		60,863			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			60,863	60,863		60,863		60,863			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,753,214	404,618	2,312,163	4,469,995		4,469,995	(481,219)	3,988,776			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	(53,421)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(3,191)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(19,007)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,619)		\$	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)	(405,600)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (405,600)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (481,219)		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
SKOKIE MEADOWS NURSING CENTER #2

Report Period Beginning: ID# 0048942
Ending: 01/01/2011
12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		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
MARC APPEL	50	CAMBRIDGE NURSING REHAB CENTER	SKOKIE	SKOKIE CAMBRIDGE		
JOAN WILLEY	50			REALTY LLC	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 903,121	SKOKIE CAMBRIDGE REALTY, LLC		\$	(903,121)	1
2	V	30	DEPRECIATION		SKOKIE CAMBRIDGE REALTY, LLC		76,504	76,504	2
3	V	32	INTEREST		SKOKIE CAMBRIDGE REALTY, LLC		388,482	388,482	3
4	V	36	MIP INSURANCE		SKOKIE CAMBRIDGE REALTY, LLC		32,535	32,535	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			\$ 903,121			\$ 497,521	\$ * (405,600)	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 SKOKIE MEADOWS NURSING CENTER # 0048942 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	JOAN WILLEY	CEO	ADMINISTRATIVE	50.00				MGMT FEE	\$ 312,000	17-3	1
2											2
3											3
4	MARK APPEL	CFO	FINANCIAL	50.00	312,000						4
5					CAMBRIDGE NURSING						5
6					REHAB CENTER						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 312,000		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 SKOKIE MEADOWS NURSING CENTER #2 # 0048942 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 SKOKIE CAMBRIDGE REALTY
Street Address 9615 N. KNOX
City / State / Zip Code SKOKIE
Phone Number (847)679-4161
Fax Number (847)679-3241

	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	1	\$ 76,504	\$	1	\$ 76,504	1
	2	32	INTEREST	DIRECT	1	388,482		1	388,482	2
	3	36	MIP INSURANCE	DIRECT	1	32,535		1	32,535	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				\$ 497,521	\$		\$ 497,521	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	SKOKIE CAMBRIDGE REALTY, LLC						\$					\$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	\$37,760.00	10/17/07	6,822,050	6,542,721	11/1/42	5.7500	378,192		2
3	JACOB GRAF		X	WORKING CAPITAL	\$8,333.00	11/1/07	773,986		2/1/15	7.0000	7,614		3
4	DIAMOND BANK		X	WORKING CAPITAL	\$3,700.00		200,000	40,678	12/24/12	4.2500	3,756		4
5													5
	Working Capital												
6													6
7	DIAMOND BANK												7
8													8
9	TOTAL Facility Related				\$49,793.00		\$ 7,796,036	\$ 6,583,399			\$ 389,562		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$ 7,796,036	\$ 6,583,399			\$ 389,562		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.		\$	190,000	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.)		\$	186,788	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,212)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	200,000	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.		\$	196,788	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007	180,527	9	
		2008	185,185	10	
		2009	147,107	11	
		2010	186,788	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FOR BHF USE ONLY
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.				14	FROM R. E. TAX STATEMENT FOR 2010 \$
				15	PLUS APPEAL COST FROM LINE 5 \$
				16	LESS REFUND FROM LINE 6 \$
				17	AMOUNT TO USE FOR RATE CALCULATION \$

- 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.

FACILITY NAME	<u>SKOKIE MEADOWS NURSING CENTER #2</u>	COUNTY	<u>COOK</u>
FACILITY IDPH LICENSE NUMBER	<u>0048942</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>BOB KAGDA</u>		
TELEPHONE	<u>(847) 675-3585</u>	FAX #:	<u>(847) 675-5777</u>

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: 22,213

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

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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			2007	\$ 275,250	1
2					2
3	TOTALS			\$ 275,250	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	111		2007		\$ 2,365,250	\$ 60,647	39	\$ 60,647	\$	\$ 252,696
5										
6										
7										
8										
	Improvement Type**									
9	WALL UNITS			2008	8,200	210	39	210		736
10	BASEMENT STAIRCASE			2008	4,895	126	39	126		440
11	INSTALLED REMOTE ANNAUNCIATOR PANEL			2008	6,850	176	39	176		616
12	INSTALL NEW GUIDES FOR ELEVATOR			2008	3,578	92	39	92		322
13	INSTALLED NEW TEKMAR CONTROL FOR BOILERS			2008	2,549	65	39	65		228
14	ELECTRICAL SERVICE			2008	2,650	68	39	68		238
15	ROOF TOP UNIT			2008	12,800	328	39	328		1,148
16	FIRE ALARM SYSTEM DEVICES			2009	29,065	745	39	745		2,201
17	SPRINKLER SYSTEM			2009	8,076	207	39	207		615
18	WALLCOVERING CORRIDOR AND LOBBY			2010	9,190	236	39	236		462
19	SHOWERS ROOMS FLOOR REPLACEMENT			2010	18,730	480	39	480		940
20	NORT DINING ROOM PARTITION			2010	4,650	119	39	119		233
21	MAIN DINING ROOM NEW CEILING			2010	7,385	189	39	189		370
22	DOCTOR OFFICE NEW WALL & CEILING			2010	3,072	79	39	79		155
23	NURSING OFFICE WALL COVERING			2010	3,188	82	39	82		160
24	BASEMENT FLOORING NEW TILES			2010	15,600	400	39	400		783
25	FRONT ENTRY WAY WALL COVERING			2010	15,600	400	39	400		783
26	PAINTING CEILING			2010	26,720	685	39	685		1,342
27	DOORS			2010	14,175	363	39	363		711
28	MOLDED TO RAIL FINISH BLACK PAINT			2010	6,000	154	39	154		302
29										
30	RESIDENT ROOM & PART OF HALLWAY FLOORING			2011	12,395	318	39	318		318
31	CONCRETE WORK			2011	11,880	304	39	304		304
32	HAT WATER SYSTEM			2011	20,433	524	39	524		524
33										
34										
35										
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)		\$ 2,612,931	\$ 66,997		\$ 66,997	\$	\$ 266,627	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	\$169,401	\$32,490	\$16,940	\$(15,550)	10 YRS	\$45,594	71
72	Current Year Purchases	2,160	2,160	108	(2,052)	10 YRS	108	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		15,857	15,857				74
75	TOTALS	\$171,561	\$50,507	\$32,905	\$(17,602)		\$45,702	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	ADMINISTRATOR	2008 LEXUS ES350	2008	\$39,429	\$11,500		\$(11,500)	3 YRS	\$39,429	76
77	ADMINISTRATOR	2012 CADILLAC CTS	2012	36,479	36,479	12,160	(24,319)	3 YRS	12,160	77
78										78
79										79
80	TOTALS			\$75,908	\$47,979	\$12,160	\$(35,819)		\$51,589	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)	\$3,135,650	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$165,483	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$112,062	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(53,421)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$363,918	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

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:				\$			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

X

NO
16. Rental Amount for movable equipment: \$8,381Description: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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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	\$		\$	\$		\$	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							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs			N/A				7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 0	\$ 0		\$ 0	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	\$ 79,449	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (142,077))	1,247,881		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	800		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM CAMBRIDGE	733,378		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,061,508	\$	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	247,681		15
16	Equipment, at Historical Cost	247,468		16
17	Accumulated Depreciation (book methods)	(187,333)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 307,816	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,369,324	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 85,527	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,820		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	200,000		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)	\$ 343,347	\$	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)	\$ 343,347	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,025,977	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,369,324	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,211,932	1
2	Restatements (describe):		2
3	SKOKIE MEADOWS ELIMINATION ACCOUNT	40,787	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,252,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	217,258	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	(444,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (226,742)	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)	\$ 2,025,977	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	\$ 4,682,896	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,682,896	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,357	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)	\$ 4,357	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,687,253	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	736,885	31
32	Health Care	1,518,295	32
33	General Administration	955,603	33
	B. Capital Expense		
34	Ownership	1,198,349	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,863	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,469,995	40
41	Income before Income Taxes (line 30 minus line 40)**	217,258	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 217,258	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

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

****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	1,976	2,200	\$ 75,792	\$ 34.45	1
2	Assistant Director of Nursing	1,872	2,125	70,261	33.06	2
3	Registered Nurses	12,135	13,123	376,914	28.72	3
4	Licensed Practical Nurses	2,148	2,268	53,593	23.63	4
5	CNAs & Orderlies	32,925	36,346	429,969	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,328	2,576	38,386	14.90	9
10	Activity Assistants	2,763	3,033	36,105	11.90	10
11	Social Service Workers	7,456	8,296	164,372	19.81	11
12	Dietician					12
13	Food Service Supervisor	1,136	1,368	18,468	13.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,176	15,267	132,301	8.67	15
16	Dishwashers					16
17	Maintenance Workers	1,800	1,984	25,564	12.89	17
18	Housekeepers	14,484	15,797	162,352	10.28	18
19	Laundry					19
20	Administrator	1,976	2,160	75,876	35.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,027	2,219	29,973	13.51	23
24	Clerical					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					31
32	Other Health Care <u>MDS</u>	1,920	2,125	63,288	29.78	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	101,122	110,887	\$ 1,753,214 *	\$ 15.81	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	54	\$ 7,776	1-3	35
36	Medical Director	250	12,560	9-3	36
37	Medical Records Consultant	47	4,512	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	44	6,589	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	54	493	11-3	44
45	Social Service Consultant	54	493	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	250	2,400	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	753	\$ 34,823		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.

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
MARGARET O'BRIEN	ADMINISTRATOR	0	\$ 75,876	Workers' Compensation Insurance		\$ 24,291	IDPH License Fee	\$
			0	Unemployment Compensation Insurance		8,538	Advertising: Employee Recruitment	0
			0	FICA Taxes		133,105	Health Care Worker Background Check	0
				Employee Health Insurance		136,780	(Indicate # of checks performed)	
				Employee Meals		12,118	Patient Background Checks	0
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	3,191
				EMPLOYEE BENEFITS - OTHER		6,638	MARKETING/ADV/PROMO	19,007
				EMPLOYEE PHYSICAL EXAMS		1,225	LICENSES/DUES/SUBSCRIPTIONS	19,626
				PENSION/PROFIT SHARING PLANS		22,219	MGMT CO ALLOC	
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(3,191)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(19,007)
Description			Amount				Yellow page advertising	(0)
JOAN WILEY MANAGEMENT FEES			\$ 312,000					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 344,914	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,626
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
PAYCHEX	DATA PROCESSING		\$ 10,572				Out-of-State Travel	\$
JOHN P. FITZGERALD	LEGAL FEES		35,000					
JOHNSON GOLDRERG	ACCOUNTING FEES		1,250					
KRUPNICK BOKOR KAGDA	ACCOUNTING FEES		4,200				In-State Travel	
FLS GROUP LLC	ACCOUNTING FEES		3,500					0
							Seminar Expense	
								0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$
			\$ 54,522					

* 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?

YES

If YES, give association name and amount.

ALLIANCE FOR LIVING \$8,658
- (3)

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

YES

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

YES
- (4)

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

NO

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

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

10 YR
- (6)

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

\$

0

Line

10-2
- (7)

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

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

60,863

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

12,118

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

5%

d. Have vehicle usage logs been maintained?

NO

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

NO

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

YES

g. Does the facility transport residents to and from day training?

NO

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

\$

N/A
- (17)

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

NO

Firm Name:
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.