

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0050997

Facility Name: Marion Rehab & Nrsg Ctr

Address: 1301 E Deyoung Marion 62959
Number City Zip Code

County: Williamson

Telephone Number: (708) 236-0000 Fax # (708) 236-0001

HFS ID Number:

Date of Initial License for Current Owners: 06/01/10

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Dan Gaafar Telephone Number: (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/12 to 12/31/12 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.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Alan Irni
(Title) CFO

Paid
Preparer

(Signed)
(Print Name and Title) Dan Gaafar Partner
(Firm Name & Address) Bradley Associates
201 S. Capitol Avenue, Indianapolis IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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

Facility Name & ID Number Marion Rehab & Nrsg Ctr# 0050997 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 bedsN/A

	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>125</u>	Skilled (SNF)	<u>125</u>	<u>45,750</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>125</u>	TOTALS	<u>125</u>	<u>45,750</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>21,522</u>	<u>2,517</u>	<u>4,954</u>	<u>28,993</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>21,522</u>	<u>2,517</u>	<u>4,954</u>	<u>28,993</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 63.37%

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?

YESG. 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 06/01/10

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

YES ☒Date 06/01/10NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 53 and days of care provided 3,963Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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	193,889	10,078	7,253	211,220		211,220	(70)	211,150			1
2	Food Purchase		163,862		163,862		163,862		163,862			2
3	Housekeeping	144,353	16,466		160,819		160,819		160,819			3
4	Laundry	82,509	14,154		96,663		96,663		96,663			4
5	Heat and Other Utilities			117,158	117,158		117,158	2,150	119,308			5
6	Maintenance	26,510	21,561	18,071	66,142		66,142	324	66,466			6
7	Other (specify):*											7
8	TOTAL General Services	447,261	226,121	142,482	815,864		815,864	2,404	818,268			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,074,587	89,477	55,860	1,219,924		1,219,924	(7,805)	1,212,119			10
10a	Therapy			478,112	478,112		478,112		478,112			10a
11	Activities	39,714	2,408		42,122		42,122		42,122			11
12	Social Services	23,770		5,214	28,984		28,984		28,984			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			3,125	3,125		3,125		3,125			15
16	TOTAL Health Care and Programs	1,138,071	91,885	547,111	1,777,067		1,777,067	(7,805)	1,769,262			16
	C. General Administration											
17	Administrative	41,554			41,554		41,554		41,554			17
18	Directors Fees											18
19	Professional Services			211,143	211,143		211,143	(174,516)	36,627			19
20	Dues, Fees, Subscriptions & Promotions			2,975	2,975		2,975	95	3,070			20
21	Clerical & General Office Expenses	63,688	23,652	53,918	141,258		141,258	72,062	213,320			21
22	Employee Benefits & Payroll Taxes			290,402	290,402		290,402	26,240	316,642			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,293	2,293		2,293	5,398	7,691			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,882	68,882		68,882	380	69,262			26
27	Other (specify):*											27
28	TOTAL General Administration	105,242	23,652	629,613	758,507		758,507	(70,341)	688,166			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,690,574	341,658	1,319,206	3,351,438		3,351,438	(75,742)	3,275,696			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 (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			34,537	34,537		34,537	64,924	99,461			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			19,047	19,047		19,047	(978)	18,069			32
33	Real Estate Taxes			59,053	59,053		59,053		59,053			33
34	Rent-Facility & Grounds			701,923	701,923		701,923	3,836	705,759			34
35	Rent-Equipment & Vehicles							75	75			35
36	Other (specify):*											36
37	TOTAL Ownership			815,375	815,375		815,375	67,857	883,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			250	250		250		250			38
39	Ancillary Service Centers		113,853		113,853		113,853		113,853			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			362,458	362,458		362,458		362,458			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		113,853	362,708	476,561		476,561		476,561			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,690,574	455,511	2,497,289	4,643,374		4,643,374	(7,885)	4,635,489			45

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

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,662	30		9
10	Interest and Other Investment Income	(978)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	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	(5,460)	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	(3,277)	21		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 54,877		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(62,762)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (62,762)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (7,885)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Marion Rehab & Nrsg Ctr

	ID#	0050997
Report Period Beginning:		1/1/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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
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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marion Rehab & Nrsg Ctr # 0050997 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(70)	0	0	0	0	0	0	0	0	0	0	(70)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,150	0	0	0	0	0	0	0	0	0	2,150	5
6	Maintenance	0	324	0	0	0	0	0	0	0	0	0	324	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(70)	2,474	0	0	0	0	0	0	0	0	0	2,404	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(7,805)	0	0	0	0	0	0	0	0	0	(7,805)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(7,805)	0	0	0	0	0	0	0	0	0	(7,805)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(174,516)	0	0	0	0	0	0	0	0	0	(174,516)	19
20	Fees, Subscriptions & Promotions	0	95	0	0	0	0	0	0	0	0	0	95	20
21	Clerical & General Office Expenses	(8,737)	75,951	4,848	0	0	0	0	0	0	0	0	72,062	21
22	Employee Benefits & Payroll Taxes	0	26,240	0	0	0	0	0	0	0	0	0	26,240	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,398	0	0	0	0	0	0	0	0	0	5,398	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	380	0	0	0	0	0	0	0	0	0	380	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(8,737)	(66,452)	4,848	0	0	0	0	0	0	0	0	(70,341)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,807)	(71,783)	4,848	0	0	0	0	0	0	0	0	(75,742)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marion Rehab & Nrsg Ctr # 0050997 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	64,662	262	0	0	0	0	0	0	0	0	0	64,924	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(978)	0	0	0	0	0	0	0	0	0	0	(978)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	3,836	0	0	0	0	0	0	0	0	0	3,836	34
35	Rent-Equipment & Vehicles	0	75	0	0	0	0	0	0	0	0	0	75	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	63,684	4,173	0	0	0	0	0	0	0	0	0	67,857	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	54,877	(67,610)	4,848	0	0	0	0	0	0	0	0	(7,885)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven Blisko	70	Anna Rehabilitation & Nursing Center	Anna	Senior Healthcare	Skokie	Management Co.
A&F General Partnership	25	Carbondale Rehabilitation & Nursing Center	Carbondale	Management		
Ted Lerman	5	Cobden Rehabilitation & Nursing Center	Cobden			
		Herrin Rehabilitation & Nursing Center	Herrin			
		Marion Rehabilitation & Nursing Center	Marion			
		Alton Rehabilitation & Nursing Center	Alton			
		Chester Rehabilitation & Nursing Center	Chester			

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing Wages	\$ 37,576	Senior Healthcare Management		\$ 29,771	\$ (7,805)	1
2	V	21	Payroll	23,742	Senior Healthcare Management		99,471	75,729	2
3	V	5	Utilities		Senior Healthcare Management		2,150	2,150	3
4	V	19	Professional Services	191,000	Senior Healthcare Management		16,484	(174,516)	4
5	V	20	Licenses & Fees		Senior Healthcare Management		95	95	5
6	V	21	Office Expense		Senior Healthcare Management		222	222	6
7	V	22	Employee Benefits		Senior Healthcare Management		26,240	26,240	7
8	V	24	Travel/Seminar		Senior Healthcare Management		5,398	5,398	8
9	V	26	Insurance		Senior Healthcare Management		380	380	9
10	V	30	Depreciation Expense		Senior Healthcare Management		262	262	10
11	V	34	Rent Expense		Senior Healthcare Management		3,836	3,836	11
12	V	35	Equipment Lease		Senior Healthcare Management		75	75	12
13	V	6	Repairs and Maintenance		Senior Healthcare Management		324	324	13
14	Total			\$ 252,318			\$ 184,708	\$ * (67,610)	14

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

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	21	Office Supplies	\$	Senior Healthcare Management		\$ 4,848	\$ 4,848	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								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			\$			\$ 4,848	\$ * 4,848	39

* 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			Midwest Rehabilitation & Nursing Center	Belleville				1
2			Columbia Rehabilitation & Nursing Center	Columbia				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 Marion Rehab & Nrsg Ctr # 0050997 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Bank Leumi USA		x	Working Capital	None	8/1/12		1,500,000	450,000	8/31/13		4.5000	19,047	6	
7														7	
8														8	
9	TOTAL Facility Related						\$	1,500,000	\$	450,000			\$	19,047	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	1,500,000	\$	450,000			\$	19,047	15

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

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

B. Real Estate Taxes

[illegible]

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Marion Rehab & Nrsg Ctr

COUNTY

Williamson

FACILITY IDPH LICENSE NUMBER

0050997

CONTACT PERSON REGARDING THIS REPORT

Dan Gaafar

TELEPHONE

317-237-5500

FAX #:

317-237-5503

A.
Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 07-17-151-001	Nursing Facility	\$ 60,121.74	\$ 60,121.74
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 60,121.74	\$ 60,121.74

B.
Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,500 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? (X) YES () NO
If so, please complete the following:

1. Total Amount Incurred: 12,225 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 815 4. Dates Incurred: Prior to 6/1/10

Nature of Costs: Organizational 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

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	125				\$	\$		\$	\$	4	
5										5	
6										6	
7										7	
8										8	
	Improvement Type**										
9	Windows & Doors			6/1/2010	5,700	146	39	146		377	9
10	Humidifier - NOT USED FOR CAPITAL RATE INCREASE			6/1/2010	676	17	39	17		44	10
11	Heat & Cool System - NOT USED FOR CAPITAL RATE INCREASE			6/1/2010	2,434	62	39	62		160	11
12	Heating System - NOT USED FOR CAPITAL RATE INCREASE			6/1/2010	5,949	153	39	153		395	12
13	Heating System - NOT USED FOR CAPITAL RATE INCREASE			6/1/2010	1,082	28	39	28		73	13
14	Fire Sprinklers			2011	10,018	257	39	257		492	14
15	Fire Sprinklers			2011	75,795	1,944	39	1,944		2,916	15
16	Roof Repairs			2011	9,750	250	39	250		417	16
17	Panelling			2011	9,398	241	39	241		341	17
18	Exterior work: columns, access panel, sconces, soffit			2011	30,000	769	39	769		1,154	18
19	Lobby:Demolition, Lighting/Electrical, Painting, Flooring,										19
20	Trim, Millwork			2011	101,615	2,606	39	2,606		3,909	20
21	Wall covering & ceiling tiles in Admissions office			2011	7,735	198	39	198		297	21
22	Nurses Station: wallpaper, reface desk, lighting, painting			2011	21,087	541	39	541		811	22
23	Flooring & Painting Vestibule			2011	5,687	146	39	146		219	23
24	Lighting, wallpaper, floor tile, kitchen cabinets for diniing			2011	31,194	800	39	800		1,200	24
25	Additional parking spots/ asphalt			2011	61,666	1,581	39	1,581		2,372	25
26	Rewire failing door closures			2011	3,800	97	39	97		146	26
27	Refinish doors			2011	16,500	423	39	423		635	27
28	New ceiling tiles & basket lighting fixtures			2011	16,000	410	39	410		615	28
29	New windows & glass door			2011	27,000	692	39	692		1,038	29
30	Install EIFS and paint			2011	68,000	1,744	39	1,744		2,616	30
31	Custom exterior sign			2011	19,000	487	39	487		731	31
32	PTAC units			2011	38,000	974	39	974		1,461	32
33	New kitchen tile			2011	10,800	277	39	277		415	33
34	Steel Valve			2011	2,300	59	39	59		88	34
35	Hot water Boilers Repair			2011	2,000	51	39	51		77	35
36	Roof engineering fee			2011	4,500	115	39	115		173	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	2	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	Resident Rooms: door handles, ceiling tiles, paint, flooring,		\$	\$		\$	\$	\$	37
38	lighting fixtures	2011	138,348	3,547	39	3,547		5,321	38
39	Corridors: handrails, signs, doors, ceiling tiles, lighting	2011	130,900	3,356	39	3,356		5,034	39
40	Windows & Painting of Laundry Room	2011	3,300	85	39	85		126	40
41	HVACs	2011	32,400	831	39	831		1,246	41
42	Landscaping	2011	12,500	321	39	321		481	42
43	Drainage	2011	4,600	118	39	118		177	43
44	Custom laminate nurses station	2011	16,900	433	39	433		650	44
45	Restrooms: Molding, chair rail, door, tile, paint, toilets, mirror	2011	22,000	564	39	564		846	45
46	Whirlpool Tub, plumbing, wall tiles	2011	12,000	308	39	308		462	46
47	Shower room: door, tile, paint, shower stalls, bathtub, lights	2011	55,000	1,410	39	1,410		2,115	47
48	Patio: concrete, doors, drainage	2011	41,600	1,067	39	1,067		1,600	48
49	Dining: Molding, chair rail, ceiling tiles, wallcovering, signs	2011	50,535	1,296	39	1,296		1,944	49
50	New doors and walls in medicine storage room	2011	6,000	154	39	154		231	50
51	Storage Room: new wall, door and paint	2011	5,500	141	39	141		212	51
52	Toilets, sinks, mirrors, lighting grab bars in resd bathrooms	2011	30,000	769	39	769		1,154	52
53	Roof	2011	83,000	2,128	39	2,128		3,192	53
54	Toilets, sinks, mirrors, lighting grab bars in resd bathrooms	2011	10,000	256	39	256		384	54
55	Call Bell System and Wander Management System	2011	61,000	1,564	39	1,564		2,346	55
56	Med room& MOP : closet door, sink, counter, lighting, paint	2011	5,700	146	39	146		219	56
57	Bathroom: flooring, sink, toilet, lighting, grab bars. Paint	2011	4,100	105	39	105		158	57
58	Concrete patio	2011	6,300	162	39	162		243	58
59	Sink room: tile, backsplash, paint, countertops, cabinets	2011	4,000	103	39	103		154	59
60	Woodlock Kick Plates	2011	7,900	203	39	203		304	60
61	Refinish nurse station, quartz countertop	2011	5,300	136	39	136		204	61
62	Flooring for vestibule	2011	2,300	59	39	59		88	62
63	Seating Areas: door, paint, lighting, ceiling tile, drywall, flooring	2011	8,100	208	39	208		312	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,346,969	\$ 34,537		\$ 34,537	\$	\$ 52,374	70

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

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	\$297,768	\$	\$64,924	\$64,924	5	\$297,768	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$297,768	\$	\$64,924	\$64,924		\$297,768	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)			\$	1,644,737
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	34,537
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	99,461
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	64,924
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	350,142

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Southern Illinois Healthcare Realty
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1995	68	5/15/10	\$ 701,923	20		3
4	Additions	2001	57					4
5								5
6								6
7	TOTAL		125		\$ 701,923			7

10. Effective dates of current rental agreement:

Beginning 6/1/10

Ending 5/31/30

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

	Fiscal Year Ending	Annual Rent
12.	12/31/13	\$ 753,182
13.	12/31/14	\$ 786,873
14.	12/31/15	\$ 809,731

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

N/A

N/A

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: \$ N/A
- Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

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

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

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

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

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

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

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

		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	10a-3	hrs	\$		\$ 217,790	\$		\$ 217,790	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			42,776			42,776	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			217,546			217,546	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				102,564		102,564	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology and Lab	39-2					11,290		11,290	13
14	TOTAL			\$		\$ 478,112	\$ 113,853		\$ 591,965	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	\$ 14,491	\$ 14,491	1
2	Cash-Patient Deposits	(11,448)	(11,448)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,517,438	1,517,438	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 1,520,481	\$ 1,520,481	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	1,346,968	1,346,968	15
16	Equipment, at Historical Cost	297,768	297,768	16
17	Accumulated Depreciation (book methods)	(350,142)	(350,142)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,105)	(2,105)	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)	\$ 1,304,714	\$ 1,304,714	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,825,195	\$ 2,825,195	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 524,566	\$ 524,566	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,365	170,365	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	<u>Working Capital Note</u>	450,000	450,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,144,931	\$ 1,144,931	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)	\$ 1,144,931	\$ 1,144,931	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,680,264	\$ 1,680,264	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,825,195	\$ 2,825,195	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,526,902	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,526,902	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,153,362	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	(1,000,000)	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)	\$ 153,362	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)	\$ 1,680,264	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marion Rehab & Nrsg Ctr# 0050997Report Period Beginning: 1/1/12Ending: 12/31/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1	2	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,880,745	1
2	Discounts and Allowances for all Levels	677,003	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,557,748	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	192,235	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 192,235	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	41,238	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,571	19
20	Radiology and X-Ray	969	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,777	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	978	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 978	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)	\$ 5,796,738	30

	1	2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	815,864	31
32	Health Care	1,777,067	32
33	General Administration	758,507	33
	B. Capital Expense		
34	Ownership	815,375	34
	C. Ancillary Expense		
35	Special Cost Centers	114,103	35
36	Provider Participation Fee	362,458	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,643,374	40
41	Income before Income Taxes (line 30 minus line 40)**	1,153,364	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,153,364	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,553,210	44
45	Private Pay - Net Inpatient Revenue	264,056	45
46	Medicare - Net Inpatient Revenue	1,359,190	46
47	Other-(specify)	381,292	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,557,748	49

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

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

*** 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	1,983	2,066	\$ 55,898	\$ 27.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,143	6,466	126,674	19.59	3
4	Licensed Practical Nurses	21,654	22,494	352,096	15.65	4
5	CNAs & Orderlies	50,521	52,293	491,210	9.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,120	4,333	39,714	9.17	9
10	Activity Assistants					10
11	Social Service Workers	1,448	1,479	23,770	16.07	11
12	Dietician	20,215	21,848	193,889	8.87	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,773	2,002	26,510	13.24	17
18	Housekeepers	15,964	17,059	144,353	8.46	18
19	Laundry	9,079	9,758	82,509	8.46	19
20	Administrator	1,101	1,122	41,554	37.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,658	7,013	63,688	9.08	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(specify)					32
33	Other(specify)	2,485	2,736	48,709	17.80	33
34	TOTAL (lines 1 - 33)	143,144	150,669	\$ 1,690,574 *	\$ 11.22	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	207	\$ 7,253	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	63	3,125	15-3	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	149	5,214	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	419	\$ 15,592		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

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

** See instructions.

STATE OF ILLINOIS

0050997

Report Period Beginning:

1/1/12

Page 21

Ending: 12/31/12

Facility Name & ID Number

Marion Rehab & Nrsg Ctr

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function	Ownership %	Amount		Description		Amount		Description		Amount			
Marla Fourez		Admin	0	\$ 5,967		Workers' Compensation Insurance		\$ 86,197		IDPH License Fee		\$ 1,990			
Carolyn McBride		Admin	0	13,689		Unemployment Compensation Insurance		69,371		Advertising: Employee Recruitment					
Jeffrey McDaniel		Admin	0	18,832		FICA Taxes		132,378		Health Care Worker Background Check					
Leeann Ward		Admin	0	3,067		Employee Health Insurance		15,326		(Indicate # of checks performed)					
						Employee Meals				Patient Background Checks					
						Illinois Municipal Retirement Fund (IMRF)*				Secretary of State		250			
						Employee expense		13,370		Marion Chamber of Commerce		585			
TOTAL (agree to Schedule V, line 17, col. 1)															
(List each licensed administrator separately.)				\$ 41,554											
B. Administrative - Other															
Description				Amount						Less: Public Relations Expense		()			
				\$						Non-allowable advertising		()			
										Yellow page advertising		()			
										TOTAL (agree to Sch. V,		\$ 3,070			
										line 20, col. 8)					
TOTAL (agree to Schedule V, line 17, col. 3)				\$		E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)						to Owners or Employees									
C. Professional Services															
Vendor/Payee		Type		Amount		Description		Line #	Amount	Description		Amount			
Senior Healthcare Management		Professional		\$ 191,000					\$	Out-of-State Travel		\$			
Johnson Goldberg		Accounting		2,650											
Bradley Associates		Accounting		7,643											
Law Offices of Lawren		Legal		4,341						In-State Travel					
Meyer Magence		Legal		625						Mileage		2,293			
Neal, Gerber & Eisenberg		Legal		223						Senior Travel Expense		5,398			
Bank of Leumi		LOC Fees		4,662											
										Seminar Expense					
										Entertainment Expense		()			
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL				(agree to Sch. V,					
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 211,143						line 24, col. 8)					
										\$ 7,691					

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?
If YES, give association name and amount.

No
- (3)

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

No
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
5 years
- (6)

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

\$ 745 Line N/A
- (7)

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

Yes
- (8)

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

No
- (9)

Are you presently operating under a sublease agreement?

x YES NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

x
- (11)

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

\$ 362,458
- (12)

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

No

- (13)

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

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?
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.

N/A
- (15)

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

\$ None
No Indicate the amount. \$ 0
- (16)

Travel and Transportation

a.

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

No

b.

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

No

c.

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

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

No
\$ 0
- (17)

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

No
N/A
- (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?
Attach invoices and a summary of services for all architect and appraisal fees.

Yes