

		FOR BHF USE					

LL1

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: 0049502

Facility Name: MCALLISTER NURSING & REHAB

Address: 18300 S LAVERGNE TINLEY PARK 60477
Number City Zip Code

County: COOK

Telephone Number: (708) 798-2272 Fax # (708) 798-2298

HFS ID Number:

Date of Initial License for Current Owners: 03/17/08

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: SANFORD BOKOR Telephone Number: (847) 675-3585
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 01/01/2012 to 12/31/2012 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) ELI ATKIN
(Title) MEMBER

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)
(Print Name and Title) SANFORD BOKOR PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 MCALLISTER NURSING & REHAB# 0049502 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>79</u>	Skilled (SNF)	<u>79</u>	<u>28,914</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>32</u>	Intermediate (ICF)	<u>32</u>	<u>11,712</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>111</u>	TOTALS	<u>111</u>	<u>40,626</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,870</u>	<u>2,448</u>	<u>4,376</u>	<u>22,694</u>	8
9	SNF/PED					9
10	ICF	<u>8,457</u>	<u>622</u>	<u>338</u>	<u>9,417</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,327</u>	<u>3,070</u>	<u>4,714</u>	<u>32,111</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.04%

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?

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 12/01/08

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

YES ☒Date 12/01/08NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 79 and days of care provided 3,837Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	222,363	7,957	2,174	232,494		232,494		232,494		1
2	Food Purchase		198,519		198,519	(10,651)	187,868	(1,328)	186,540		2
3	Housekeeping		7,043		7,043		7,043		7,043		3
4	Laundry		6,666	96,945	103,611		103,611		103,611		4
5	Heat and Other Utilities			78,416	78,416		78,416		78,416		5
6	Maintenance	37,752	12,091	179,131	228,974		228,974		228,974		6
7	Other (specify):*			12,472	12,472		12,472		12,472		7
8	TOTAL General Services	260,115	232,276	369,138	861,529	(10,651)	850,878	(1,328)	849,550		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,498,000	91,811	9,498	1,599,309		1,599,309		1,599,309		10
10a	Therapy	85,146		114	85,260		85,260		85,260		10a
11	Activities	82,317	5,061		87,378		87,378		87,378		11
12	Social Services	44,275		930	45,205		45,205		45,205		12
13	CNA Training										13
14	Program Transportation			1,758	1,758		1,758		1,758		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,709,738	96,872	19,500	1,826,110		1,826,110		1,826,110		16
	C. General Administration										
17	Administrative	232,779		156,332	389,111		389,111		389,111		17
18	Directors Fees										18
19	Professional Services			99,022	99,022		99,022		99,022		19
20	Dues, Fees, Subscriptions & Promotions			97,609	97,609		97,609	(92,420)	5,189		20
21	Clerical & General Office Expenses	173,726	18,371	65,335	257,432		257,432	(11,365)	246,067		21
22	Employee Benefits & Payroll Taxes			536,211	536,211	10,651	546,862	(67,137)	479,725		22
23	Inservice Training & Education			1,181	1,181		1,181		1,181		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			10,938	10,938		10,938	(9,844)	1,094		25
26	Insurance-Prop.Liab.Malpractice			223,431	223,431		223,431		223,431		26
27	Other (specify):*			23,000	23,000		23,000	(23,000)			27
28	TOTAL General Administration	406,505	18,371	1,213,059	1,637,935	10,651	1,648,586	(203,766)	1,444,820		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,376,358	347,519	1,601,697	4,325,574		4,325,574	(205,094)	4,120,480		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	0
	REPAIRS & MAINTENANCE		2,174
			0
			2,174
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		945
	CONTRACTED LAUNDRY SERVICES		96,000
			96,945
5	HEAT & OTHER UTILITIES		
	GAS HEAT		19,822
	ELECTRICITY		40,281
	WATER		13,677
	CABLE TV - LOBBY		4,636
			0
			78,416
6	MAINTENANCE		
	GROUNDS MAINTENANCE		10,177
	PAINTING & DECORATING		57
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		17,293
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		4,140
	EXTERMINATING SERVICE		3,300
	FIRE SERVICE		11,476
	CONTRACTED BUILDING MAINT		132,688
			0
			0
			0
			179,131
7	OTHER		
	SCAVENGER		11,522
	SECURITY SERVICE		950
			0
			0
			12,472
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,200
			7,200

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	1,647
	UTILIZATION REVIEW FEES	XVIII B -2	0
	PHYSICIANS	XVIII B -2	0
	PSYCHIATRIC	XVIII B -2	0
	RN CONSULTANT	XVIII B 38-2	0
	NURSING		2,746
	DENTAL		5,105
			9,498
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	114
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			114
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		930
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			930
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	1,758	1,758
		0	
17	ADMINISTRATIVE		
	MANAGEMENT FEES XIX B	156,332	156,332
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING XIX C	12,477	
	ADMINISTRATIVE CONSULTANTS XIX C	22,200	
	PROFESSIONAL FEES XIX C	64,345	
		0	99,022
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,816	
	EMPLOYEE WANT ADS XIX F	415	
	CONTRIBUTIONS VI 20 XIX F	76,604	
	DUES & SUBSCRIPTIONS XIX F	2,307	
	LICENSES & PERMITS XIX F	2,357	
	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	110	
	PATIENT BACKGROUND CHECKS XIX F	0	
			97,609
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,282	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES VI 18	11,365	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	48,688	
	MESSENGER SERVICE	0	
		0	65,335

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES XIX D	181,801	
	UNEMPLOYMENT COMPENSATION XIX D	109,938	
	WORKERS COMPENSATION INSURANC XIX D	66,964	
	HOSPITALIZATION INSURANCE XIX D	93,764	
	EMPLOYEE BENEFITS - OTHER XIX D	2,829	
	EMPLOYEE PHYSICAL EXAMS XIX D	0	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	67,137	
	PENSION/PROFIT SHARING PLANS XIX D	13,778	
	CHICAGO HEAD TAX XIX D	0	
		0	536,211
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	1,181	
			1,181
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS XIX G	0	
	TRAVEL XIX G	0	
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	10,938	
			10,938
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	223,431	
			223,431
27	OTHER		
	BAD DEBTS VI 24	23,000	
			23,000

GRAND TOTAL COLUMN 3 OTHER

1,601,697

MCALLISTER NURSING & REHAB
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	198,519
LESS SALES TAX	<u>(1,328)</u>
NET FOOD	197,191
TOTAL PATIENT CENSUS	32,111
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	96,333
ADD # EMPLOYEE MEALS/DAY	15
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	5,490
PATIENT MEALS	96,333
ADD EMPLOYEE MEALS	<u>5,490</u>
TOTAL MEALS/YEAR	101,823
NET FOOD	197,191
DIVIDE TOTAL MEALS/YEAR	<u>101,823</u>
COST PER MEAL	1.94
TIMES EMPLOYEE MEALS	<u>5,490</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>10,651</u></u>

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			15,084	15,084		15,084	199,962	215,046			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,527	84,527		84,527	238,836	323,363			32
33	Real Estate Taxes			369,444	369,444		369,444		369,444			33
34	Rent-Facility & Grounds			392,990	392,990		392,990	(392,990)				34
35	Rent-Equipment & Vehicles			16,385	16,385		16,385		16,385			35
36	Other (specify):*											36
37	TOTAL Ownership			878,430	878,430		878,430	45,808	924,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,390	210,590	315,980		315,980		315,980			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			330,496	330,496		330,496		330,496			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		105,390	541,086	646,476		646,476		646,476			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,376,358	452,909	3,021,213	5,850,480		5,850,480	(159,286)	5,691,194			45

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

		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	5,972	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,328)	2		13
14	Non-Care Related Interest	(32,775)	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	(11,365)	21		18
19	Entertainment		20		19
20	Contributions	(76,604)	20		20
21	Owner or Key-Man Insurance	(67,137)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,000)	27		24
25	Fund Raising, Advertising and Promotional	(15,816)	20		25
	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	(9,844)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (231,897)		\$	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)	72,611		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 72,611		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (159,286)		37

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

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

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

STATE OF ILLINOIS
MCALLISTER NURSING & REHAB

Report Period Beginning: ID# 0049502
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NON ALLOWABLE TRAVEL	\$ (9,844)	25	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	(9,844)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCALLISTER NURSING & REHAB

0049502

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(92,420)	0	0	0	0	0	0	0	0	0	0	(92,420)	20
21	Clerical & General Office Expenses	(11,365)	0	0	0	0	0	0	0	0	0	0	(11,365)	21
22	Employee Benefits & Payroll Taxes	(67,137)	0	0	0	0	0	0	0	0	0	0	(67,137)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(9,844)	0	0	0	0	0	0	0	0	0	0	(9,844)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(23,000)	0	0	0	0	0	0	0	0	0	0	(23,000)	27
28	TOTAL General Administration	(203,766)	0	0	0	0	0	0	0	0	0	0	(203,766)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(205,094)	0	0	0	0	0	0	0	0	0	0	(205,094)	29

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	5,972	193,990	0	0	0	0	0	0	0	0	0	199,962	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,775)	271,611	0	0	0	0	0	0	0	0	0	238,836	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(392,990)	0	0	0	0	0	0	0	0	0	(392,990)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(26,803)	72,611	0	0	0	0	0	0	0	0	0	45,808	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)	(231,897)	72,611	0	0	0	0	0	0	0	0	0	(159,286)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Yael Atkin	44	Oakridge Healthcare Center,LLC	Hillside, ILL	McAllister		
Donna Atkin	44			Property,LLC	Tinley Park ILL	Real Estate
Jay Orlinsky	5					
Helen Lacek	7			Oakridge	Hillside ILL	Real Estate
				Property, LLC		

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	\$ 392,990	McAllister Property , LLC		\$	(392,990)	1
2	V	30	DEPRECIATION				193,990	193,990	2
3	V	32	INTEREST				253,361	253,361	3
4	V	32	AMORT OF LOAN COSTS				18,250	18,250	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			\$ 392,990			\$ 465,601	\$ * 72,611	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number MCALLISTER NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ELISHA ATKIN	OTHER ADMIN	Administration					SALARY	\$ 105,168	17-1	1
2			Purchases								2
3	JOEL ATKIN	OTHER ADMIN	Administration					SALARY	49,491	17-1	3
4											4
5											5
6											6
7											7
8	Yael Atkin	MEMBER	ADMIN.	44.00				mgmt	78,166	17-3	8
9											9
10	DONNA ATKIN	MEMBER	ADMIN.	44.00				mgmt	78,166	17-3	10
11											11
12											12
13								TOTAL	\$ 310,991		13

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

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

Facility Name & ID Number MCALLISTER NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	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	MC ALLISTER PROPERTY, LLC						\$		\$			\$	1	
2	FIRST MERIT BANK		X	MORTGAGE (NET OF INT INCOME)		5/24/11		4,600,000	4,552,945	7/31/17			253,361	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		8/1/12							18,250	3
4														4
5	INSURANCE												7,326	5
	Working Capital													
6	FIRST MERIT BANK		X	WORKING CAPITAL	INT ONLY	3/17/08		600,000	769,105	REVOLV	5.0000		42,678	6
7														7
8	INFINITY FINANCIAL		X	AUTO		1/10/10		59,255	12,061		2.9000		1,748	8
9	TOTAL Facility Related					\$1,063.39		\$ 5,259,255	\$ 5,334,111			\$ 323,363	9	
	B. Non-Facility Related*													
10	BED TAX												6,086	10
11	REAL ESTATE TAXES												19,048	11
12	NATIONAL GOV'T SERVICES													12
13	JACK ATKIN												7,641	13
14	TOTAL Non-Facility Related							\$				\$ 32,775	14	
15	TOTALS (line 9+line14)							\$ 5,259,255	\$ 5,334,111			\$ 356,138	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 2011 report.		\$	317,404	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.)		\$	315,523	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,881)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	371,325	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.		\$	369,444	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	231,660	8	
		2008	287,500	9	
		2009	247,527	10	
		2010	247,404	11	
		2011	336,095	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 100%					
OF THE PRIOR YEAR REAL ESTATE TAX BILL PLUS 90,571.95 OWED					
ON 2011 TAX BILL, MINUS 55,341.65 EST REDUCTION ON 2012					
THE PAYMENT ON LINE 2 APPLIES TO THE \$70,000 FOR 2010 BILL PLUS \$245,523 FOR 2011 BILL					
		FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2011	\$		13	
14	PLUS APPEAL COST FROM LINE 5	\$		14	
15	LESS REFUND FROM LINE 6	\$		15	
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16	

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCALLISTER NURSING & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049502

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>28-33-403-043-0000</u>	<u>NURSING HOME</u>	\$ <u>285,544.12</u>	\$ <u>285,544.12</u>
2.	<u>28-33-403-007-0000</u>	<u>NURSING HOME</u>	\$ <u>46,854.71</u>	\$ <u>46,854.71</u>
3.	<u>28-33-403-008-0000</u>	<u>NURSING HOME</u>	\$ <u>3,696.06</u>	\$ <u>3,696.06</u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>336,094.89</u></u>	\$ <u><u>336,094.89</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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.**

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		2008	\$ 726,776	1
2					2
3	TOTALS			\$ 726,776	3

Facility Name & ID Number MCALLISTER NURSING & REHAB

0049502

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	111		2008		\$ 2,907,102	\$ 105,713	27.5	\$ 105,713	\$	\$ 506,541	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOORS		2008		4,517	164	27.5	164		800	9
10	COVE BASE FLOORING (LANDLORD)		2009		2,520	92	27.5	92		326	10
11	DOORS (LANDLORD)		2009		5,131	186	27.5	186		659	11
12	HANDRAILS (LANDLORD)		2009		16,217	590	27.5	590		2,089	12
13	2 NURSE STATIONS (LANDLORD)		2009		3,600	131	27.5	131		464	13
14	FIRE SPRINKLER SYSTEM (LANDLORD)		2009		2,500	91	27.5	91		322	14
15	PYROCHEM SYSTEM (LANDLORD)		2009		3,156	115	27.5	115		407	15
16	NURSE CALL LIGHT SYSTEM (LANDLORD)		2009		5,200	189	27.5	189		669	16
17	SPRINKLERS (LANDLORD)		2009		38,000	1,382	27.5	1,382		4,895	17
18	SIGNS (LANDLORD)		2009		4,781	174	27.5	174		616	18
19	ROOF (LANDLORD)		2009		11,000	399	27.5	399		1,414	19
20	CARPETING (LANDLORD)		2009		4,087	235	5	817	582	1,635	20
21	PAINTING (LANDLORD)		2009		53,725	3,094	5	10,745	7,651	21,491	21
22	CURTAINS (LANDLORD)		2009		19,732	1,137	5	3,946	2,809	7,892	22
23	BLINDS (LANDLORD)		2009		4,560	263	5	912	649	1,824	23
24	DRAPES (LANDLORD)		2010		6,677	641	5	1,335	694	1,736	24
25	DRAPES (LANDLORD)		2010		3,662		5	732	732	1,098	25
26	OUTDOOR LIGHTING (LANDLORD)		2010		7,380	492	15	492		1,230	26
27	DRAPES (LANDLORD)		2010		2,817	102	27.5	102		234	27
28	DRAIN LINE (LANDLORD)		2011		3,500	127	27.5	127		132	28
29	HOT WATER HEATER		2012		5,488	42	27.5	42		42	29
30	DRY PIPE VALVE FOR FIRE PROTECTION SYSTEM		2012		3,740	28	27.5	28		28	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,119,092	\$ 115,387		\$ 128,504	\$ 13,117	\$ 556,544	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	\$ 140,435	\$ 8,332	\$ 14,044	\$ 5,712		\$ 50,913	71
72	Current Year Purchases	4,432	2,659	222	(2,437)		222	72
73	Fully Depreciated Assets							73
74	REL PARTY		78,767	65,000	(13,767)			74
75	TOTALS	\$ 144,867	\$ 89,758	\$ 79,266	\$ (10,492)		\$ 51,135	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1996 CHEVY K1500	2009	\$ 8,500	\$ 979	\$ 850	\$ (129)		\$ 3,400	76
77	FACILITY	INFINITI G37 CONVERTIBLE	2010	64,255	2,950	6,426	3,476		19,278	77
78										78
79										79
80	TOTALS			\$ 72,755	\$ 3,929	\$ 7,276	\$ 3,347		\$ 22,678	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)	\$ 4,063,490	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 209,074	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 215,046	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,972	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 630,357	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 392,990			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 392,990			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 16,385
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 83,290	\$		\$ 83,290	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			120,558			120,558	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				99,696		99,696	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Dental Service,Radiology,Laboratory Other (specify): MED. SUPPLIES	39-3 39-2				6,742	5,694		6,742 5,694	13
14	TOTAL			\$		\$ 210,590	\$ 105,390		\$ 315,980	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	\$ 54,015	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (91,574))	1,331,411		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	269,806		6
7	Other Prepaid Expenses	7,971		7
8	Accounts Receivable (owners or related parties)	1,070,834		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,734,037	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	4,517		15
16	Equipment, at Historical Cost	217,622		16
17	Accumulated Depreciation (book methods)	(161,638)		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 (spec develop. Cost	125,793		22
23	Other(specify): due from mcallister properties	244,885		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 431,179	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,165,216	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,119,920	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	769,105		29
30	Accrued Salaries Payable	162,963		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,509		31
32	Accrued Real Estate Taxes(Sch.IX-B)	371,325		32
33	Accrued Interest Payable	12,524		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Infiniti Financial Services	12,061		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,488,407	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,557		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)	\$ 17,557	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,505,964	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 659,252	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,165,216	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 321,726	1
2	Restatements (describe):		2
3	STATE REPLACEMENT TAX	(7,728)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 313,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	375,254	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	(30,000)	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)	\$ 345,254	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)	\$ 659,252	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MCALLISTER NURSING & REHAB# 0049502Report Period Beginning: 01/01/2012Ending: 12/31/2012**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	\$ 6,206,741	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,206,741	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		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)	\$ 6,206,741	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	861,529	31
32	Health Care	1,826,110	32
33	General Administration	1,637,935	33
	B. Capital Expense		
34	Ownership	878,430	34
	C. Ancillary Expense		
35	Special Cost Centers	315,980	35
36	Provider Participation Fee	330,496	36
	D. Other Expenses (specify):		
37			37
38	OTHER EXPENSE ADJUSTMENT	(18,993)	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,831,487	40
41	Income before Income Taxes (line 30 minus line 40)**	375,254	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 375,254	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,983,655	44
45	Private Pay - Net Inpatient Revenue	460,274	45
46	Medicare - Net Inpatient Revenue	1,615,578	46
47	Other-(specify) INSURANCE	147,234	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,206,741	49

**TAX RETURN IS ON EXTENSION

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? **NO**** If not, please attach a reconciliation.

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

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,257	1,291	\$ 50,818	\$ 39.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,707	4,822	154,423	32.02	3
4	Licensed Practical Nurses	24,759	26,063	628,525	24.12	4
5	CNAs & Orderlies	57,014	59,916	609,028	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,688	1,777	85,146	47.92	8
9	Activity Director	1,892	2,102	34,808	16.56	9
10	Activity Assistants	4,303	4,732	47,509	10.04	10
11	Social Service Workers	2,032	2,074	44,275	21.35	11
12	Dietician					12
13	Food Service Supervisor	2,247	2,451	42,452	17.32	13
14	Head Cook	2,003	2,174	20,576	9.46	14
15	Cook Helpers/Assistants	9,761	10,769	113,082	10.50	15
16	Dishwashers	3,593	3,981	46,253	11.62	16
17	Maintenance Workers	1,948	2,091	37,752	18.05	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,163	2,171	78,120	35.98	20
21	Assistant Administrator	4,263	4,263	154,659	36.28	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,082	11,832	173,726	14.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,854	1,970	55,206	28.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,566	144,479	\$ 2,376,358 *	\$ 16.45	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	7,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,647	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		114	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,961		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>YES</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>NO</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u>
What was the average life used for new equipment added during this period? <u>10 YR</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line <u>10-2</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>330,496</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>YES</u></p> <p>(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? <u>NO</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>10,651</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>NO</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> 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? <u>5%</u>
d. Have vehicle usage logs been maintained? <u>NO</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>NO</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>YES</u>
g. Does the facility transport residents to and from day training? <u>NO</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>NO</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(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? <u>YES</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|---|