

		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: 0048942

Facility Name: SKOKIE MEADOWS NSG CTR #2

Address: 4600 W GOLF RD SKOKIE 60076
Number City Zip Code

County: COOK

Telephone Number: (847) 679-1157 Fax # (847) 626-0432

HFS ID Number:

Date of Initial License for Current Owners: 11/1/07

Type of Ownership:

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

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

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA 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) MARK APPEL
(Title) OWNER

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)
(Print Name and Title) BOB KAGDA VICE 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 SKOKIE MEADOWS NSG CTR #2# 0048942 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>111</u>	Skilled (SNF)	<u>111</u>	<u>40,626</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>111</u>	TOTALS	<u>111</u>	<u>40,626</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					8
9	SNF/PED					9
10	ICF	<u>26,255</u>	<u>397</u>	<u>8,690</u>	<u>35,342</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,255</u>	<u>397</u>	<u>8,690</u>	<u>35,342</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.99%

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 11/01/07

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

YES ☒ Date 11/01/07 NO ☐

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

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	139,011	11,212	7,776	157,999		157,999		157,999		1
2	Food Purchase		202,445		202,445	(6,771)	195,674		195,674		2
3	Housekeeping	163,324	25,180		188,504		188,504		188,504		3
4	Laundry		13,861		13,861		13,861		13,861		4
5	Heat and Other Utilities			77,080	77,080		77,080		77,080		5
6	Maintenance	26,970	14,283	56,536	97,789		97,789		97,789		6
7	Other (specify):*			5,215	5,215		5,215		5,215		7
8	TOTAL General Services	329,305	266,981	146,607	742,893	(6,771)	736,122		736,122		8
	B. Health Care and Programs										
9	Medical Director			13,760	13,760		13,760		13,760		9
10	Nursing and Medical Records	1,094,818	126,250	57,209	1,278,277		1,278,277		1,278,277		10
10a	Therapy										10a
11	Activities	66,779	11,515	2,242	80,536		80,536		80,536		11
12	Social Services	142,154		3,865	146,019		146,019		146,019		12
13	CNA Training										13
14	Program Transportation			249	249		249		249		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,303,751	137,765	77,325	1,518,841		1,518,841		1,518,841		16
	C. General Administration										
17	Administrative	73,377		258,000	331,377		331,377		331,377		17
18	Directors Fees										18
19	Professional Services			21,674	21,674		21,674		21,674		19
20	Dues, Fees, Subscriptions & Promotions			43,788	43,788		43,788	(22,880)	20,908		20
21	Clerical & General Office Expenses	29,322	9,135	26,592	65,049		65,049		65,049		21
22	Employee Benefits & Payroll Taxes			352,238	352,238	6,771	359,009		359,009		22
23	Inservice Training & Education			609	609		609		609		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,301	8,301		8,301		8,301		25
26	Insurance-Prop.Liab.Malpractice			69,545	69,545		69,545		69,545		26
27	Other (specify):*										27
28	TOTAL General Administration	102,699	9,135	780,747	892,581	6,771	899,352	(22,880)	876,472		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,735,755	413,881	1,004,679	3,154,315		3,154,315	(22,880)	3,131,435		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	7,776
	REPAIRS & MAINTENANCE		0
			0
			7,776
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		15,058
	ELECTRICITY		44,938
	WATER		14,884
	CABLE TV - LOBBY		2,200
			0
			77,080
6	MAINTENANCE		
	GROUNDS MAINTENANCE		2,760
	PAINTING & DECORATING		3,300
	BUILDING REPAIRS		8,449
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		12,234
	ELEVATOR MAINTENANCE & REPAIR		14,796
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,288
	FIRE SERVICE		10,691
	CONTRACTED BUILDING MAINT		3,018
			0
			0
			0
			56,536
7	OTHER		
	SCAVENGER		5,215
	SECURITY SERVICE		0
			0
			0
			5,215
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	13,760
			13,760

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		4,983
	PURCHASED SERVICES		19,405
	PSYCHO-SOCIAL CONSULTANT	XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,867
	PHARMACY CONSULTANT	XVIII B 39-2	5,954
	UTILIZATION REVIEW FEES	XVIII B -2	0
	PHYSICIANS	XVIII B -2	0
	PSYCHIATRIC	XVIII B -2	24,000
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			57,209
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	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,242
			0
			2,242
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	3,865
			3,865
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		249
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	258,000
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	11,345
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	10,329
			0
			21,674
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	15,780
	EMPLOYEE WANT ADS	XIX F	388
	CONTRIBUTIONS	VI 20 XIX F	7,100
	DUES & SUBSCRIPTIONS	XIX F	17,820
	LICENSES & PERMITS	XIX F	1,365
	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	470
	PATIENT BACKGROUND CHECKS	XIX F	865
			43,788
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	0
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		26,592
	MESSENGER SERVICE		0
			0
			26,592

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	131,414
	UNEMPLOYMENT COMPENSATION	XIX D	7,856
	WORKERS COMPENSATION INSURANC	XIX D	55,456
	HOSPITALIZATION INSURANCE	XIX D	132,490
	EMPLOYEE BENEFITS - OTHER	XIX D	4,060
	EMPLOYEE PHYSICAL EXAMS	XIX D	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	20,962
	CHICAGO HEAD TAX	XIX D	0
			0
			352,238
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		609
			609
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		8,301
			8,301
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		69,545
			69,545
27	OTHER		
	BAD DEBTS	VI 24	0
			0

GRAND TOTAL COLUMN 3 OTHER

1,004,679

SKOKIE MEADOWS NSG CTR #2
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	202,445	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	202,445	
TOTAL PATIENT CENSUS	35,342	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	106,026	
ADD # EMPLOYEE MEALS/DAY	10	
TIMES # DAYS	<u>366</u>	
TOTAL EMPLOYEE MEALS	3,660	
PATIENT MEALS	106,026	
ADD EMPLOYEE MEALS	<u>3,660</u>	
TOTAL MEALS/YEAR	109,686	
NET FOOD	202,445	
DIVIDE TOTAL MEALS/YEAR	<u>109,686</u>	
COST PER MEAL	1.85	
TIMES EMPLOYEE MEALS	<u>3,660</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>6,771</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			39,125	39,125		39,125	73,344	112,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,424	3,424		3,424	611,859	615,283			32
33	Real Estate Taxes			202,581	202,581		202,581		202,581			33
34	Rent-Facility & Grounds			1,153,121	1,153,121		1,153,121	(1,153,121)				34
35	Rent-Equipment & Vehicles			7,521	7,521		7,521		7,521			35
36	Other (specify):*							32,129	32,129			36
37	TOTAL Ownership			1,405,772	1,405,772		1,405,772	(435,789)	969,983			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			388,048	388,048		388,048		388,048			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			388,048	388,048		388,048		388,048			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,735,755	413,881	2,798,499	4,948,135		4,948,135	(458,669)	4,489,466			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	(3,160)	30		9
10	Interest and Other Investment Income	(48,601)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(7,100)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(15,780)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,641)		\$	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)	(384,028)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (384,028)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (458,669)		37

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

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

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

STATE OF ILLINOIS
SKOKIE MEADOWS NSG CTR #2

Page 5A

Report Period Beginning: ID# 0048942
Ending: 01/01/2012
12/31/2012

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 SKOKIE MEADOWS NSG CTR #2 # 0048942 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	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	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(22,880)	0	0	0	0	0	0	0	0	0	0	(22,880)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(22,880)	0	0	0	0	0	0	0	0	0	0	(22,880)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,880)	0	0	0	0	0	0	0	0	0	0	(22,880)	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	(3,160)	76,504	0	0	0	0	0	0	0	0	0	73,344	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,601)	660,460	0	0	0	0	0	0	0	0	0	611,859	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,153,121)	0	0	0	0	0	0	0	0	0	(1,153,121)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	32,129	0	0	0	0	0	0	0	0	0	32,129	36
37	TOTAL Ownership	(51,761)	(384,028)	0	0	0	0	0	0	0	0	0	(435,789)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(74,641)	(384,028)	0	0	0	0	0	0	0	0	0	(458,669)	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
MARC APPEL	50	CAMBRIDGE NURSING REHAB CENTER	SKOKIE	SKOKIE CAMBRIDGE	SKOKIE	REAL ESTATE
JOAN WILLEY	50			REALTY 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	\$ 1,153,121	SKOKIE CAMBRIDGE REALTY, LLC		\$	(1,153,121)	1
2	V	30	DEPRECIATION				76,504	76,504	2
3	V	32	INTEREST				660,460	660,460	3
4	V	36	MIP INSURANCE				32,129	32,129	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			\$ 1,153,121			\$ 769,093	\$ * (384,028)	14

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number SKOKIE MEADOWS NSG CTR #2 # 0048942 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	JOAN WILLEY	CEO	ADMINISTRATIVE	50.00				MGMT FEE	\$ 258,000	17-3	1
2											2
3											3
4	MARC APPEL	CEO	FINANCIAL	50.00	258,000						4
5					CAMBRIDGE NURSING						5
6					REHAB CENTER						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 258,000		13

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	SKOKIE CAMBRIDGE REALTY, LLC						\$					\$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	\$37,760.00	10/17/07		6,822,050		11/1/42	5.7500	654,268	2
3	JACOB GRAF		X	WORKING CAPITAL	\$8,333.00	11/1/07		773,986		2/1/15	7.0000		3
4	DIAMOND BANK		X	WORKING CAPITAL	\$3,700.00			200,000		12/24/12	4.2500	883	4
5	CAMBRIDGE REALTY		X	MORTGAGE		12/21/12		7,239,800		11/01/42	2.4000	5,309	5
	Working Capital												
6													6
7	DIAMOND BANK	X		W/C	INTEREST ONLY						6.0000	3,424	7
8													8
9	TOTAL Facility Related				\$49,793.00		\$	7,796,036	\$	7,239,800			9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$				14
15	TOTALS (line 9+line14)						\$	7,796,036	\$	7,239,800			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,129 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.			\$	200,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	192,581	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(7,419)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	210,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	202,581	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	180,527	8	
		2008	185,185	9	
		2009	147,107	10	
		2010	186,788	11	
		2011	192,581	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX 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 SKOKIE MEADOWS NSG CTR #2 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048942

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)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	10-10-304-042-0000	NURSING HOME	\$ 192,580.91	\$ 192,580.91
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 192,580.91	\$ 192,580.91

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: 22,213

B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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		2007	\$ 275,250	1
2					2
3	TOTALS			\$ 275,250	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	111		2007		\$ 2,365,250	\$ 60,647	39	\$ 60,647		\$ 313,343
5										
6										
7										
8										
	Improvement Type**									
9	WALL UNITS			2008	8,200	210	39	210		946
10	BASEMENT STAIRCASE			2008	4,895	126	39	126		566
11	INSTALLED REMOTE ANNAUNCIATOR PANEL			2008	6,850	176	39	176		792
12	INSTALL NEW GUIDES FOR ELEVATOR			2008	3,578	92	39	92		414
13	INSTALLED NEW TEKMAR CONTROL FOR BOILERS			2008	2,549	65	39	65		293
14	ELECTRICAL SERVICE			2008	2,650	68	39	68		306
15	ROOF TOP UNIT			2008	12,800	328	39	328		1,476
16	FIRE ALARM SYSTEM DEVICES			2009	29,065	745	39	745		2,946
17	SPRINKLER SYSTEM			2009	8,076	207	39	207		822
18	WALCOVERING CORRIDOR AND LOBBY			2010	9,190	236	39	236		698
19	SHOWERS ROOMS FLOOR REPLACEMENT			2010	18,730	480	39	480		1,420
20	NORT DINING ROOM PARTITION			2010	4,650	119	39	119		352
21	MAIN DINING ROOM NEW CEILING			2010	7,385	189	39	189		559
22	DOCTOR OFFICE NEW WALL & CEILING			2010	3,072	79	39	79		234
23	NURSING OFFICE WALL COVERING			2010	3,188	82	39	82		242
24	BASEMENT FLOORING NEW TILES			2010	15,600	400	39	400		1,183
25	FRONT ENTRY WAY WALL COVERING			2010	15,600	400	39	400		1,183
26	PAINTING CEILING			2010	26,720	685	39	685		2,027
27	DOORS			2010	14,175	363	39	363		1,074
28	MOLDED TO RAIL FINISH BLACK PAINT			2010	6,000	154	39	154		456
29										
30	RESIDENT ROOM & PART OF HALLWAY FLOORING			2011	12,395	325	39	325		643
31	CONCRETE WORK			2011	11,880	311	39	311		615
32	HAT WATER SYSTEM			2011	20,433	536	39	536		1,060
33										
34	Removed existing nursing station,counter top,and the cabinets.									
35	Replace cabinets and countertops with a new design. Top countertop									
36	made from 1 1/4 granite. Bottom from laminate matching granite top counter,									

*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	made from 1 1/4 granite. Bottom from laminate maching granite top counter		\$	\$		\$	\$		37
38	Built new cabinets made from 3/4 inch mellami and standard gradee								38
39	laminate. Removed existing vinyl tiles from the floor,also prepared								39
40	the floor using power grinder to smooth the surfacethe for new								40
41	wood grain 7x48 inch vinyl planks. Removed existing formica								41
42	countertops and vinyl tiles from the floor								42
43	Removed some door from existing cabinets. Replaced with new								43
44	laminate look. Built new cabinets for the fax machine. Installed								44
45	new wood grain 7x48 inch vinyl plank flooring, tops and new sink.								45
46	Removed and replaced 30x80 inch solid core entry door to med room.								46
47	Laminated both sides of the door with cherry laminate look and decorative trim.								47
48	Installed quarter inch 12x12 cork tiles between top cabinets								48
49	and countertop. Installed 6 inch ceramic base to finish.	2012	11,100	273	39	273		273	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,624,031	\$ 67,296		\$ 67,296	\$	\$ 333,923	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	\$171,561	\$32,476	\$17,156	\$(15,320)	10 YRS	\$62,858	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		15,857	15,857				74
75	TOTALS	\$171,561	\$48,333	\$33,013	\$(15,320)		\$62,858	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMINISTRATOR	2008 LEXUS ES350	2008	\$39,429	\$	\$	\$	3 YRS	\$39,429	76
77	ADMINISTRATOR	2012 CADILLAC CTS	2012	36,479		12,160	12,160	3 YRS	24,320	77
78										78
79										79
80	TOTALS			\$75,908	\$	\$12,160	\$12,160		\$63,749	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,146,75081
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$115,62982
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$112,46983**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(3,160)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$460,53085

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

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

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.
13.
14.

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: \$ 7,521
- 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			N/A		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_____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(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	39-3	hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs			N/A				7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$	0	\$ 0	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	\$ 36,175	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (142,077))	1,521,031		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,559,206	\$	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	258,781		15
16	Equipment, at Historical Cost	247,468		16
17	Accumulated Depreciation (book methods)	(226,458)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 279,791	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,838,997	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 89,689	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,246		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	210,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO DPA	107,742		36
37	SKOKIE 1 & 2 ELIM ACCT	241,919		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 715,596	\$	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)	\$ 715,596	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,123,401	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,838,997	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,025,977	1
2	Restatements (describe):		2
3	SKOKIE MEADOWS ELIMINATION ACCOUNT	109,430	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,135,407	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(444,006)	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	(568,000)	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)	\$ (1,012,006)	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)	\$ 1,123,401	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SKOKIE MEADOWS NSG CTR #2# 0048942Report 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	\$ 4,451,169	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,451,169	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***	48,601	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48,601	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	4,359	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,359	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,504,129	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	742,893	31
32	Health Care	1,518,841	32
33	General Administration	892,581	33
	B. Capital Expense		
34	Ownership	1,405,772	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	388,048	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,948,135	40
41	Income before Income Taxes (line 30 minus line 40)**	(444,006)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (444,006)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,068,876	44
45	Private Pay - Net Inpatient Revenue	52,545	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>VETERAN</u>	1,329,748	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,451,169	49

**TAX RETURN PREPARED ON CASH BASIS

* 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.

Facility Name & ID Number SKOKIE MEADOWS NSG CTR #2# 0048942Report Period Beginning: 01/01/2012Ending: 12/31/2012

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	1,944	2,125	\$ 74,415	\$ 35.02	1
2	Assistant Director of Nursing	1,920	2,125	71,375	33.59	2
3	Registered Nurses	11,780	13,001	379,521	29.19	3
4	Licensed Practical Nurses	2,080	2,268	56,011	24.70	4
5	CNAs & Orderlies	33,828	37,234	446,886	12.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,585	38,855	15.03	9
10	Activity Assistants	1,952	2,080	27,924	13.43	10
11	Social Service Workers	7,088	7,976	142,154	17.82	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,064	22,904	11.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,360	12,326	116,107	9.42	15
16	Dishwashers					16
17	Maintenance Workers	1,817	2,082	26,970	12.95	17
18	Housekeepers	13,363	14,390	163,324	11.35	18
19	Laundry					19
20	Administrator	2,008	2,080	73,377	35.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,958	2,174	29,322	13.49	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS	1,880	2,125	66,610	31.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,922	106,635	\$ 1,735,755 *	\$ 16.28	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	54	\$ 7,776	1-3	35
36	Medical Director	250	13,760	9-3	36
37	Medical Records Consultant	47	2,867	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	55	5,954	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	59	2,242	11-3	44
45	Social Service Consultant	59	3,865	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	524	\$ 36,464		49

C. CONTRACT NURSES

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

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							N/A						
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?

YES
- (2)

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

YES

If YES, give association name and amount.

ALLIANCE FOR LIVING \$10,248
- (3)

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

NO

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

N/A
- (4)

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

NO

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

Have you properly capitalized all major repairs and equipment purchases?

YES

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

10 YR
- (6)

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

\$ 0

Line

10-2
- (7)

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

YES

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

Are you presently operating under a sale and leaseback arrangement?

NO

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

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

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

YES

NO

X

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

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

\$ 388,048

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

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

NO

If YES, attach an explanation of the allocation.

- (13)

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

YES
- (14)

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

NO

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

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

\$ 6,771

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (16)

Travel and Transportation

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

NO

If YES, attach a complete explanation.

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

NO

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

\$

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

5%

d. Have vehicle usage logs been maintained?

NO

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

NO

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

YES

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

NO

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

\$ N/A
- (17)

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

NO

Firm Name:
- (18)

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

YES
- (19)

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

N/A

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