

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0047126</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>St Antonys Nsg & Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>767 30th St</u> <u>Rock Island</u> <u>61201</u>			
Number City Zip Code			
County: <u>Rock Island</u>			
Telephone Number: <u>(309) 788-7631</u> Fax # <u>(309) 788-9823</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>5/19/05</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Amanda Springborn</u>			
Telephone Number: <u>(314) 925-3838</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) <u>McGladrey LLP</u>	
		<u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	
		(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr

0047126 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

N/A

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	44	44	16,104	1
2	Skilled (SNF)			2
3	Skilled Pediatric (SNF/PED)			3
4	86	86	31,476	4
5	Intermediate (ICF)			5
6	Intermediate/DD			6
7	Sheltered Care (SC)			7
8	ICF/DD 16 or Less			8
9	130	TOTALS	47,580	9

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	3,120	1,453	4,060	8,633	8
9	SNF/PED					9
10	ICF	24,765	5,191		29,956	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,885	6,644	4,060	38,589	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.10%

D. How many bed-hold days during this year were paid by the Department?

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☒

NO

☐

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 05/19/2005

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

YES

☒

Date 05/19/2005

NO

☐

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

YES

☒

NO

☐

If YES, enter number of beds certified 44 and days of care provided 4,060

Medicare 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.

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	223,361	20,028	9,340	252,729		252,729		252,729			1
2	Food Purchase		246,300		246,300		246,300		246,300			2
3	Housekeeping	133,107	34,998		168,105		168,105		168,105			3
4	Laundry	52,360	49,228		101,588		101,588		101,588			4
5	Heat and Other Utilities			219,605	219,605		219,605		219,605			5
6	Maintenance	144,647		116,656	261,303		261,303		261,303			6
7	Other (specify):*											7
8	TOTAL General Services	553,475	350,554	345,601	1,249,630		1,249,630		1,249,630			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,781,498	120,421	7,695	1,909,614		1,909,614		1,909,614			10
10a	Therapy											10a
11	Activities	64,553	14,056	284	78,893		78,893		78,893			11
12	Social Services	3,606		1,386	4,992		4,992		4,992			12
13	CNA Training											13
14	Program Transportation			3,206	3,206		3,206		3,206			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,849,657	134,477	34,171	2,018,305		2,018,305		2,018,305			16
	C. General Administration											
17	Administrative	117,098		352,941	470,039		470,039	(352,941)	117,098			17
18	Directors Fees											18
19	Professional Services			85,129	85,129		85,129	32,909	118,038			19
20	Dues, Fees, Subscriptions & Promotions			22,880	22,880		22,880	979	23,859			20
21	Clerical & General Office Expenses	90,175	3,501	44,370	138,046		138,046	144,599	282,645			21
22	Employee Benefits & Payroll Taxes			312,341	312,341		312,341		312,341			22
23	Inservice Training & Education											23
24	Travel and Seminar			356	356		356	21,378	21,734			24
25	Other Admin. Staff Transportation			10,951	10,951		10,951		10,951			25
26	Insurance-Prop.Liab.Malpractice			69,179	69,179		69,179	66,834	136,013			26
27	Other (specify):* Mgmt Alloc-Benefits							21,497	21,497			27
28	TOTAL General Administration	207,273	3,501	898,147	1,108,921		1,108,921	(64,745)	1,044,176			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,610,405	488,532	1,277,919	4,376,856		4,376,856	(64,745)	4,312,111			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			36,468	36,468		36,468	207,840	244,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			90,458	90,458		90,458	727,472	817,930			32
33	Real Estate Taxes							64,813	64,813			33
34	Rent-Facility & Grounds			1,115,383	1,115,383		1,115,383	(1,102,519)	12,864			34
35	Rent-Equipment & Vehicles			12,963	12,963		12,963	4,242	17,205			35
36	Other (specify):*											36
37	TOTAL Ownership			1,255,272	1,255,272		1,255,272	(98,152)	1,157,120			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		368,947	639,621	1,008,568		1,008,568		1,008,568			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			436,900	436,900		436,900		436,900			42
43	Other (specify):* Non-Allowable Cos	100,040		201,728	301,768		301,768	(301,768)				43
44	TOTAL Special Cost Centers	100,040	368,947	1,278,249	1,747,236		1,747,236	(301,768)	1,445,468			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,710,445	857,479	3,811,440	7,379,364		7,379,364	(464,665)	6,914,699			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,183)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(145,845)	30		9
10	Interest and Other Investment Income	(1,932)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(181,314)	43		24
25	Fund Raising, Advertising and Promotional	(3,952)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(146,766)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (489,992)		\$	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)	25,327		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 25,327		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (464,665)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salaries	\$ (100,040)	43	1
2	Labs - Part A	(5,718)	43	2
3	Radiology & EKG - Medicare	25	43	3
4	Offset Miscellaneous Income	(2,518)	21	4
5	Chamber of Commerce Dues	(700)	20	5
6	Other Services - Medicare	(586)	43	6
7	Disallow interest in excess of prime paid to related party	(9,332)	32	7
8	Disallow Marketing Consultation	(13,238)	19	8
9	Nonallowable legal fees	(8,496)	19	9
10	Offset Amortization of Goodwill	(6,163)	32	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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23				23
24				24
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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	(146,766)		49

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
Suzanne Koenig	90%	Lena Living Center	Lena	SAK Management Ser	Northfield	Mgmt. Co.
Gary Weintraub	10%	Amboy Acquisitions Nursing & Rehab.	Amboy	St. Anthony's Property	Rock Island	Real Estate Entity
				Lena Property Partner	Lena	Real Estate Entity
				Amboy Property Partn	Amboy	Real Estate Entity

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Clerical - Other	\$	St. Anthony's Property Partners	100.00%	\$ 1,966	\$ 1,966	1
2	V	36	Mortgage Insurance		St. Anthony's Property Partners	100.00%	62,458	62,458	2
3	V	30	Depreciation		St. Anthony's Property Partners	100.00%	352,582	352,582	3
4	V	32	Amortization		St. Anthony's Property Partners	100.00%	30,737	30,737	4
5	V	32	Loan Interest		St. Anthony's Property Partners	100.00%	712,045	712,045	5
6	V	33	Real Estate Taxes		St. Anthony's Property Partners	100.00%	64,813	64,813	6
7	V	34	Rent- Facility & Grounds	1,115,383	St. Anthony's Property Partners	100.00%		(1,115,383)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,115,383			\$ 1,224,601	\$ * 109,218	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$	SAK Management Services, LLC	90.00%	\$ 154	\$ 154	15
16	V	17	Administrative	352,941	SAK Management Services, LLC	90.00%		(352,941)	16
17	V	19	Professional Fees	46,446	SAK Management Services, LLC	90.00%	103,106	56,660	17
18	V	20	Dues,Fees & Subs		SAK Management Services, LLC	90.00%	1,679	1,679	18
19	V	21	Clerical		SAK Management Services, LLC	90.00%	145,151	145,151	19
20	V	24	Travel/Seminar		SAK Management Services, LLC	90.00%	21,378	21,378	20
21	V	26	Insurance - Prop/Liability		SAK Management Services, LLC	90.00%	4,376	4,376	21
22	V	27	EE Benefits		SAK Management Services, LLC	90.00%	19,480	19,480	22
23	V	30	Depreciation Expense		SAK Management Services, LLC	90.00%	1,103	1,103	23
24	V	32	Interest		SAK Management Services, LLC	90.00%	2,117	2,117	24
25	V	34	Rent - Facility & Grounds		SAK Management Services, LLC	90.00%	12,864	12,864	25
26	V	35	Rent - Eqpt. & Vehicles		SAK Management Services, LLC	90.00%	4,088	4,088	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 399,387			\$ 315,496	\$ * (83,891)	39

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

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

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

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

Facility Name & ID Number St Antonys Nsg & Rehab Ctr # 0047126 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 ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization SAK Management Services, LLC
Street Address 1 Northfield Plaza, Suite 480
City / State / Zip Code Northfield, IL 60093
Phone Number (847) 446-8400
Fax Number (847) 446-8432

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1						\$			\$	1
2	6	Maintenance	SAK Management Fees	1,462,931	13	637		352,941	154	2
3	19	Professional Fees	SAK Management Fees	1,462,931	13	427,371		352,941	103,106	3
4	20	Dues,Fees & Subs	SAK Management Fees	1,462,931	13	6,959		352,941	1,679	4
5	21	Clerical	SAK Management Fees	1,462,931	13	601,648	570,158	352,941	145,151	5
6	24	Travel/Seminar	SAK Management Fees	1,462,931	13	88,611		352,941	21,378	6
7	26	Insurance - Prop/Liability	SAK Management Fees	1,462,931	13	18,137		352,941	4,376	7
8	27	EE Benefits	SAK Management Fees	1,462,931	13	80,745		352,941	19,480	8
9	30	Depreciation Expense	SAK Management Fees	1,462,931	13	4,571		352,941	1,103	9
10	32	Interest	SAK Management Fees	1,462,931	13	8,775		352,941	2,117	10
11	34	Rent - Facility & Grounds	SAK Management Fees	1,462,931	13	53,323		352,941	12,864	11
12	35	Rent - Eqpt. & Vehicles	SAK Management Fees	1,462,931	13	16,944		352,941	4,088	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					\$ 1,307,721	\$ 570,158		\$ 315,496	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	HUD		X	Mortgage		12/17/09	\$ 11,995,400	\$ 11,887,899	12/18/2047	0.0675	\$ 712,045	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Cole Taylor Bank		X	LOC		12/28/05		750,912	04/01/2013	various	59,491	6
7	SAK Management	X		Working Capital		12/17/09	186,449	81,449	12/17/2013	0.1500	11,913	7
8	See Schedule 9A	X		Working Capital		Various	163,386	1,698,818	12/31/2013	0.6000	16,054	8
9	TOTAL Facility Related						\$ 12,345,235	\$ 14,419,078			\$ 799,503	9
	B. Non-Facility Related*											
10								See Schedule 9A			18,427	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 18,427	14
15	TOTALS (line 9+line14)						\$ 12,345,235	\$ 14,419,078			\$ 817,930	15

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

* 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.)

St. Anthony's Nursing & Rehab Center
Provider #: 0047126
01/01/12 - 12/31/12

Schedule 9A

Page 9 Line 8: Other Working Capital Loans

Lender	Related	Purpose	Amount		Maturity	Interest Rate	Interest Exp
			Original	Balance			
Suzanne A Koenig	Yes	Work Capital	163,386	274,386	12/31/2013	0.0600	16,054
SAK Management	Yes	Work Capital		1,424,432	Demand	Zero	-
			163,386	1,698,818			16,054

Page 9 Line 10 Column 10: Other Loan & Interest Activity

Amortization of Loan fees	24,574
Disallow excess related party interest	(9,332)
LOC - Other Fees	3,000
Interest Income Offset	(1,932)
Allocation from Mgmt Co.	2,117
	18,427

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

B. Real Estate Taxes

[illegible]

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Anthony's Nsg & Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Suzanne Koenig

TELEPHONE (847) 446-8400 FAX #: (847) 446 -8432

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 Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 09-231-19-00	Long Term Care Property	\$ 1,469.92	\$ 1,469.92
2. 09-430-04-00	Long Term Care Property	\$ 78,180.96	\$ 78,180.96
3. 09-430-05-00	Long Term Care Property	\$ 7,442.88	\$ 7,442.88
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 87,093.76	\$ 87,093.76

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 providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

149,308

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

5

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

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

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

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	Facility	319,300	2005	\$ 155,000	1
2					2
3	TOTALS	319,300		\$ 155,000	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	140		2005	1974	\$ 2,050,000	\$	35	\$ 58,571	\$ 58,571	\$ 468,568
5										
6										
7										
8										
	Improvement Type**									
9	Security & Monitoring System			2005	3,522		20	176	176	1,559
10	Boiler			2005	24,087		10	2,409	2,409	18,068
11	Boiler repairs			2008	18,233	3,189	7	2,604	(585)	11,717
12	Heater System Reapair			2009	4,635	1,135	7	662	(473)	2,648
13	Boiler Repairs			2010	22,384	3,199	7	3,199		7,997
14	New Water Heater			2011	7,920		20	396	396	594
15	drain repairs			2011	3,108	622	7	444	(178)	666
16	Oxygen fill system-cylinders & cart			2011	2,669	534	7	384	(150)	576
17	Broken steam line repairs			2011	4,195	839	7	600	(239)	900
18										
19	Complete facility rehabilitation & renovation			2012	6,510,694		40	81,384	81,384	81,384
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,651,446	\$ 9,518		\$ 150,829	\$ 141,311	\$ 594,677	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	\$ 347,602	\$ 26,176	\$ 34,760	\$ 8,584	10	\$ 265,064	71
72	Current Year Purchases	768,099	76,810	56,516	(20,294)	5	56,516	72
73	Fully Depreciated Assets							73
74	Management Co allocation			1,103	1,103			74
75	TOTALS	\$ 1,115,701	\$ 102,986	\$ 92,379	\$ (10,607)		\$ 321,580	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	Ford Winstar	2005	\$ 1,506	\$	\$	\$	5	\$ 1,506
77	Facility	Snow Plow Truck	2010	5,500	2,126	1,100	(1,026)	5	2,750
78									78
79									79
80	TOTALS			\$ 7,006	\$ 2,126	\$ 1,100	\$ (1,026)		\$ 4,256

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)			\$ 9,929,153	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 114,630	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 244,308	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 129,678	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 920,513	

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	N/A	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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	Management Co allocation				12,864			6
7	TOTAL				\$ 12,864			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
- N/A

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms: N/A
- *

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: \$ 17,205
- Description: Nursing Rental - 9229; Copier Rental - 3734; Home Office Alloc. - 4242
- (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			\$ N/A	\$	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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

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.)

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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(2),(3)	hrs	\$	3,129	\$ 225,307	\$ 1,636	3,129	\$ 226,943	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,059	76,274		1,059	76,274	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,685	337,318		4,685	337,318	4
5	Physician Care	39(3)	visits		10	722		10	722	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				289,829		289,829	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					77,482		77,482	12
13	Other (specify):									13
14	TOTAL			\$	8,883	\$ 639,621	\$ 368,947	8,883	\$ 1,008,568	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	\$ 196,964	\$ 196,964	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 603,124)	1,648,217	1,648,217	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	105,532	105,532	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Loan Insurance Costs</u>		466,903	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,950,713	\$ 2,417,616	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,000	13
14	Buildings, at Historical Cost		8,560,694	14
15	Leasehold Improvements, at Historical Cost		90,752	15
16	Equipment, at Historical Cost	208,695	1,122,707	16
17	Accumulated Depreciation (book methods)	(125,858)	(920,513)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		92,500	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(47,263)	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)	\$ 82,837	\$ 9,053,877	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,033,550	\$ 11,471,493	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,057,937	\$ 1,057,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	750,912	750,912	29
30	Accrued Salaries Payable	156,942	156,942	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,284	19,284	31
32	Accrued Real Estate Taxes(Sch.IX-B)		89,949	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to/From St. Anthony's Prop, LLC</u>	2,411,372	2,411,372	36
37	<u>See Schedule 17A</u>	3,994	3,994	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,400,441	\$ 4,490,390	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,780,267	1,780,267	39
40	Mortgage Payable		11,887,899	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)	\$ 1,780,267	\$ 13,668,166	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,180,708	\$ 18,158,556	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,147,158)	\$ (6,687,063)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,033,550	\$ 11,471,493	48

*(See instructions.)

St. Anthony's Nursing & Rehab Center
Provider #: 0047126
01/01/12 - 12/31/12

Schedule 17A

XV. Balance Sheet

	After	
Ln-37 Other Current Liabilities	Operating	Consolidation
Due to SAK - Contract Payroll	3,795	3,795
Employee Loans, Adv, Wage Assignment	199	199
Total	3,994	3,994

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,835,498)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,835,498)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(311,661)	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	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (311,660)	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)	\$ (4,147,158)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr

0047126

Report Period Beginning: 01/01/2012

Ending: 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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,829,888	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,829,888	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	228,930	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 228,930	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,932	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,932	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Income-2,518; Vending Commission-4,435</u>	6,953	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,953	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,067,703	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,249,630	31
32	Health Care	2,018,305	32
33	General Administration	1,108,921	33
	B. Capital Expense		
34	Ownership	1,255,272	34
	C. Ancillary Expense		
35	Special Cost Centers	1,310,336	35
36	Provider Participation Fee	436,900	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,379,364	40
41	Income before Income Taxes (line 30 minus line 40)**	(311,661)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (311,661)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,928,272	44
45	Private Pay - Net Inpatient Revenue	802,783	45
46	Medicare - Net Inpatient Revenue	1,835,605	46
47	Other-(specify) <u>Insurance</u>	263,228	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,829,888	49

* 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.

^ - LLC Members are cash basis taxpayers.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,976	2,080	\$ 60,861	\$ 29.26	1
2	Assistant Director of Nursing	1,768	2,080	47,120	22.65	2
3	Registered Nurses	9,575	10,125	227,094	22.43	3
4	Licensed Practical Nurses	26,089	27,875	493,600	17.71	4
5	CNAs & Orderlies	75,036	80,144	882,706	11.01	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	5,945	6,272	64,553	10.29	10
11	Social Service Workers	152	152	3,606	23.72	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	17,397	18,829	223,361	11.86	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	13,940	14,966	144,647	9.67	17
18	Housekeepers	13,998	15,076	133,107	8.83	18
19	Laundry	5,150	5,724	52,360	9.15	19
20	Administrator	1,860	2,388	117,098	49.04	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	6,849	7,742	90,175	11.65	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care Care Plan Coord.	3,807	3,960	70,117	17.71	32
33	Other(specify) Marketing	4,192	4,512	100,040	22.17	33
34	TOTAL (lines 1 - 33)	187,732	201,925	\$ 2,710,445 *	\$ 13.42	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	172	\$ 9,340	1(3)	35
36	Medical Director	120	21,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	7,695	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	284	11(3)	44
45	Social Service Consultant	52	1,386	12(3)	45
46	Other(specify) Administrative	12	437	21(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	512	\$ 40,742		49

C. CONTRACT NURSES

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

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

** See instructions.

St. Anthony's Nursing & Rehab Center
Provider #:
01/01/12 - 12/31/12

Schedule 21C

XIX.C. Professional Services

Vendor/Payee	Type	Amount
Shaw Gussis Fishman Glanz Wolfson & Tobin	Legal Fees	6,103
Aron, Goldghen, Davis and Gasmisa	Legal Fees	150
Polsinelli & Shughart	Legal Fees	4,879
Stephen Sher	Legal Fees	707
Betty, Neuman & McMahon	Legal Fees	1,536
McGladrey LLP	Accounting Fee	9,534
Sharon Haugh Lofgren	Accounting Fee	3,600
Richard Peelo & Associates Inc.	Accounting Fee	4,200
Govig and Associates Inc.	Consulting HR	15,300
Kay Wallin - Marketing	Consulting Pyysical Plant	2,613
Midwest Renovation & Restoration Inc.	Consulting Fee	9,793
SAK Contract payroll Health Insurance	Consulting Fee	2,017
Healthcare Investigators	Consulting Fee	1,671
Ivans Inc.	Data Processing	1,379
Payday-USA	Data Processing	2,964
Health Data Systems Inc.	Data Processing	4,372
LTC Solutions Inc.	Data Processing	1,217
ADP	Data Processing	169
Charles Kempton	Marketing Consultant	10,625
Personnel Planners, Inc.	U/C Rate Consultant	2,300
Total for Page 3, Line 19, Column 3	Total	85,129
Reclassify employee Benefits		(2,017)
Nonallowable Marketing Expense		(13,238)
Nonallowable Legal		(8,496)
Allocation from Mgmt. Co.	Consulting	56,660
Total for Page 3, Line 19, Column 8		118,038

XX. GENERAL INFORMATION:

- (1)

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

No

(2)

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

Yes

If YES, give association name and amount.

IL Council on Long Term Care \$13,026

(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?

N/A

(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?

7

(6)

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

\$

20,147

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.

N/A

(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.

N/A

(11)

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

\$

436,900

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.

\$

0

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

0
- (16)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

0

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

N/A

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

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

N/A

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

N/A

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

N/A

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:

N/A
- (18)

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

Yes
- (19)

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

Yes

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