FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049502

Facility Name: MCALLISTER NURSING AND REHAB

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

County: COOK

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 01/01/2010 to 12/31/2010 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) _____ (Date)
(Type or Print Name) ELI ATKIN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(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 MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,835	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	11,680	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,528	3,868	6,806	25,202	8
9	SNF/PED					9
10	ICF	9,149	546	261	9,956	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,677	4,414	7,067	35,158	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.78%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 79 and days of care provided 4,608

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	206,218	19,131	297	225,646		225,646		225,646			1
2	Food Purchase		182,316		182,316	(14,418)	167,898	(1,397)	166,501			2
3	Housekeeping	3,343	3,049		6,392		6,392		6,392			3
4	Laundry		239	100,227	100,466		100,466		100,466			4
5	Heat and Other Utilities			111,285	111,285		111,285		111,285			5
6	Maintenance	24,823	11,098	200,647	236,568		236,568		236,568			6
7	Other (specify):*			10,817	10,817		10,817		10,817			7
8	**TOTAL General Services**	234,384	215,833	423,273	873,490	(14,418)	859,072	(1,397)	857,675			8
	B. Health Care and Programs											
9	Medical Director			16,200	16,200		16,200		16,200			9
10	Nursing and Medical Records	1,415,083	102,456	11,785	1,529,324		1,529,324		1,529,324			10
10a	Therapy	93,728	2,759	5,630	102,117		102,117		102,117			10a
11	Activities	99,558	5,271		104,829		104,829		104,829			11
12	Social Services	11,630			11,630		11,630		11,630			12
13	CNA Training											13
14	Program Transportation			631	631		631		631			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,619,999	110,486	34,246	1,764,731		1,764,731		1,764,731			16
	C. General Administration											
17	Administrative	196,429		238,012	434,441		434,441		434,441			17
18	Directors Fees											18
19	Professional Services			90,917	90,917		90,917		90,917			19
20	Dues, Fees, Subscriptions & Promotions			74,258	74,258		74,258	(66,660)	7,598			20
21	Clerical & General Office Expenses	150,054	22,952	88,491	261,497		261,497	(35,250)	226,247			21
22	Employee Benefits & Payroll Taxes			487,326	487,326	14,418	501,744	(70,299)	431,445			22
23	Inservice Training & Education			1,522	1,522		1,522		1,522			23
24	Travel and Seminar			785	785		785		785			24
25	Other Admin. Staff Transportation			1,877	1,877		1,877		1,877			25
26	Insurance-Prop.Liab.Malpractice			151,368	151,368		151,368		151,368			26
27	Other (specify):*			73,783	73,783		73,783	(73,783)				27
28	**TOTAL General Administration**	346,483	22,952	1,208,339	1,577,774	14,418	1,592,192	(245,992)	1,346,200			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,200,866	349,271	1,665,858	4,215,995		4,215,995	(247,389)	3,968,606			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.

Facility Name & ID#: MCALLISTER NURSING AND REHAB #0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		297	
			0	297
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,227	
	CONTRACTED LAUNDRY SERVICES		96,000	100,227
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		33,929	
	ELECTRICITY		56,792	
	WATER		17,202	
	CABLE TV - LOBBY		3,362	
			0	111,285
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,951	
	PAINTING & DECORATING		499	
	BUILDING REPAIRS		10,726	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		17,882	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		1,968	
	EXTERMINATING SERVICE		4,225	
	FIRE SERVICE		13,652	
	CONTRACTED BUILDING MAINT.		145,744	
			0	
			0	
			0	200,647
7	**OTHER**			
	SCAVENGER		9,913	
	SECURITY SERVICE		904	
			0	
			0	10,817
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	16,200	16,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,770	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	4,700	
	NURSING PROGRAM CONSULTANT		1,444	
	DENTAL		3,871	11,785
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,800	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	2,830	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				5,630
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MCALLISTER NURSING AND REHAB #0049502 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		631	631
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	238,012	238,012
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,578	
	ADMINISTRATIVE CONSULTANTS	XIX C	28,080	
	PROFESSIONAL FEES	XIX C	41,259	
			0	90,917
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	913	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,685	
	EMPLOYEE WANT ADS	XIX F	972	
	CONTRIBUTIONS	VI 20 XIX F	58,062	
	DUES & SUBSCRIPTIONS	XIX F	2,732	
	LICENSES & PERMITS	XIX F	3,394	
	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	500	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				74,258
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,261	
	EQUIPMENT REPAIR & MAINTENANCE		1,255	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	34,323	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		49,652	
	MESSENGER SERVICE		0	
			0	88,491

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	168,519	
	UNEMPLOYMENT COMPENSATION	XIX D	54,477	
	WORKERS COMPENSATION INSURANC	XIX D	61,753	
	HOSPITALIZATION INSURANCE	XIX D	109,759	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,469	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	70,299	
	PENSION/PROFIT SHARING PLANS	XIX D	19,050	
	CHICAGO HEAD TAX	XIX D	0	
			0	487,326
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,522	
				1,522
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	785	
				785
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,877	
				1,877
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		151,368	
				151,368
27	**OTHER**			
	BAD DEBTS	VI 24	73,783	
				73,783

GRAND TOTAL COLUMN 3 OTHER **1,665,858**

MCALLISTER NURSING AND REHAB
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	182,316
LESS SALES TAX	(1,397)
NET FOOD	180,919
TOTAL PATIENT CENSUS	35,158
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	105,474
ADD # EMPLOYEE MEALS/DAY	25
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	9,125
PATIENT MEALS	105,474
ADD EMPLOYEE MEALS	9,125
TOTAL MEALS/YEAR	114,599
NET FOOD	180,919
DIVIDE TOTAL MEALS/YEAR	114,599
COST PER MEAL	1.58
TIME EMPLOYEE MEALS	9,125
EMPLOYEE MEAL RECLASSIFICATION	**14,418**
	========

Facility Name & ID Number MCALLISTER NURSING AND REHAB #0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			47,533	47,533		47,533	259,280	306,813			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,657	47,657		47,657	181,780	229,437			32
33	Real Estate Taxes			234,697	234,697		234,697		234,697			33
34	Rent-Facility & Grounds			505,884	505,884		505,884	(505,884)				34
35	Rent-Equipment & Vehicles			21,342	21,342		21,342	(2,672)	18,670			35
36	Other (specify):* amort.comp. software			13,482	13,482		13,482		13,482			36
37	**TOTAL Ownership**			870,595	870,595		870,595	(67,496)	803,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,445	164,709	314,154		314,154		314,154			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,773	60,773		60,773		60,773			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		149,445	225,482	374,927		374,927		374,927			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,200,866	498,716	2,761,935	5,461,517		5,461,517	(314,885)	5,146,632			45

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,143)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,397)	2		13
14	Non-Care Related Interest	(7,817)	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	(34,323)	21		18
19	Entertainment	(913)	20		19
20	Contributions	(58,062)	20		20
21	Owner or Key-Man Insurance	(70,299)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,783)	27		24
25	Fund Raising, Advertising and Promotional	(7,685)	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 SEE PAGE 5A	(3,599)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (260,021)		$	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)	(54,864)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (54,864)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (314,885)		37

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

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

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

STATE OF ILLINOIS

MCALLISTER NURSING AND REHAB

ID# 0049502

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AUTO LEASING	$ (2,672)	35	1
2	MARKETING SALARY	(927)	21	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**	(3,599)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,397)	0	0	0	0	0	0	0	0	0	0	(1,397)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,397)	0	0	0	0	0	0	0	0	0	0	(1,397)	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	(66,660)	0	0	0	0	0	0	0	0	0	0	(66,660)	20
21	Clerical & General Office Expenses	(35,250)	0	0	0	0	0	0	0	0	0	0	(35,250)	21
22	Employee Benefits & Payroll Taxes	(70,299)	0	0	0	0	0	0	0	0	0	0	(70,299)	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):*	(73,783)	0	0	0	0	0	0	0	0	0	0	(73,783)	27
28	**TOTAL General Administration**	(245,992)	0	0	0	0	0	0	0	0	0	0	(245,992)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(247,389)	0	0	0	0	0	0	0	0	0	0	(247,389)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,143)	261,423	0	0	0	0	0	0	0	0	0	259,280	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,817)	189,597	0	0	0	0	0	0	0	0	0	181,780	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(505,884)	0	0	0	0	0	0	0	0	0	(505,884)	34
35	Rent-Equipment & Vehicles	(2,672)	0	0	0	0	0	0	0	0	0	0	(2,672)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,632)	(54,864)	0	0	0	0	0	0	0	0	0	(67,496)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(260,021)	(54,864)	0	0	0	0	0	0	0	0	0	(314,885)	45

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JOEL ATKIN	44			McALLISTER	TINLEY PARK	REAL ESTATE
DONNA ATKIN	44			PROPERTY,LLC		
JAY ORLINSKY	5			IH MANAGEMENT	TINLEY PARK	MANAGEMENT
HELEN LACEK	7			INNOVATIVE		O/S CLERICAL
				HEALTHCARE		& THERAPY

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 505,884	MC ALLISTER PROPERTY, LLC		$	$ (505,884)	1
2	V	30	DEPRECIATION				261,423	261,423	2
3	V	32	INTEREST				174,896	174,896	3
4	V	32	AMORT LOAN COSTS				14,701	14,701	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			$ 505,884			$ 451,020	$ * (54,864)	14

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ELISHA ATKIN	ADMINISTRATIVE	ADMIN.,PURCH					SALARY	$ 103,403	17-1	1
2											2
3	JOEL ATKIN			44.00				SALARY	14,100	17-1	3
4											4
5	HELEN LACEK	MEMBER	ADMIN.	7.00	$80,000			ADMIN CONS	28,080	19-3	5
6					OAKRIDGE NURSING						6
7					& REHAB						7
8	DONNA ATKIN	MEMBER	ADMIN.	44.00				MGMT FEE	119,006	17-3	8
9											9
10	YAEL ATKIN	ADMINISTRATIVE						MGMT FEE	119,006	17-3	10
11											11
12											12
13								TOTAL	$ 383,595		13

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

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: McALLISTER PROPERTY, LLC
Street Address: 18300 S LAVERGNE
City / State / Zip Code: TINLEY PARK, ILL 60477
Phone Number: (708)798-2272
Fax Number: (708)798-2298

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 261,423	$	1	$ 261,423	1
2	32	INTEREST	DIRECT COSTS	1	1	174,896		1	174,896	2
3	32	AMORT LOAN COSTS	DIRECT COSTS	1	1	14,701		1	14,701	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 451,020	$		$ 451,020	25

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MC ALLISTER PROPERTY, LLC						$	$			$	1
2	FIRST BANK		X	MORTGAGE		3/17/08	4,600,000	4,600,000	3/16/11	3.7500	174,896	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN				3,675			14,701	3
4												4
5												5
	Working Capital											
6	FIRST MERIT BANK		X	WORKING CAPITAL	INT ONLY	3/17/08	600,000	440,055	REVOLV	5.0000	27,794	6
7											11,140	7
8	INFINITY FINANCIAL		X	AUTO	$1,063.39	6/10/10	59,255	52,717	5/31/15	2.9000	906	8
9	TOTAL Facility Related				$1,063.39		$ 5,259,255	$ 5,096,447			$ 229,437	9
	B. Non-Facility Related*											
10	BED TAX										6,078	10
11	REAL ESTATE TAXES										1,198	11
12	PAYROLL TAX										541	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,817	14
15	TOTALS (line 9+line14)						$ 5,259,255	$ 5,096,447			$ 237,254	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **N/A** **Line #** **36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 247,500	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.)		$ 247,527	2
3. Under or (over) accrual (line 2 minus line 1).		$ 27	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 317,527	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** $ 12,857 **For** 2007 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (12,857)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 234,697	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006		9
2007	231,660	10
2008	287,500	11
2009	247,527	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL PLUS 70,000 OWED ON 2008 TAX BILL THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCALLISTER NURSING AND REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049502

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-33-403-043-0000	NURSING HOME	$ 218,239.19	$ 218,239.19
2.	28-33-403-007-0000	NURSING HOME	$ 25,064.70	$ 25,064.70
3.	28-33-403-008-0000	NURSING HOME	$ 4,222.80	$ 4,222.80
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 247,526.69	$ 247,526.69

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2008	$ 726,776	1
2					2
3	TOTALS			$ 726,776	3

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	111		2008		$ 2,907,102	$ 105,713	27.5	$ 105,713	$	$ 295,115	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOORS			2008	4,517	164	27.5	164		472	9
10	COVE BASE FLOORING (LANDLORD)			2009	2,520	92	27.5	92		142	10
11	DOORS (LANDLORD)			2009	5,131	186	27.5	186		287	11
12	HANDRAILS (LANDLORD)			2009	16,217	590	27.5	590		909	12
13	2 NURSE STATIONS (LANDLORD)			2009	3,600	131	27.5	131		202	13
14	FIRE SPRINKLER SYSTEM (LANDLORD)			2009	2,500	91	27.5	91		140	14
15	PYROCHEM SYSTEM (LANDLORD)			2009	3,156	115	27.5	115		177	15
16	NURSE CALL LIGHT SYSTEM (LANDLORD)			2009	5,200	189	27.5	189		291	16
17	SPRINKLERS (LANDLORD)			2009	38,000	1,382	27.5	1,382		2,131	17
18	SIGNS (LANDLORD)			2009	4,781	174	27.5	174		268	18
19	ROOF (LANDLORD)			2009	11,000	399	27.5	399		616	19
20	CARPETING (LANDLORD)			2009	4,087	654	5	654		818	20
21	PAINTING (LANDLORD)			2009	53,725	8,596	5	8,596		10,746	21
22	CURTAINS (LANDLORD)			2009	19,732	3,157	5	3,157		3,946	22
23	BLINDS (LANDLORD)			2009	4,560	730	5	730		912	23
24	DRAPES (LANDLORD)			2010	6,677	4,007	5	4,007		401	24
25	DRAPES (LANDLORD)			2010	3,662	3,662	5	3,662		366	25
26	OUTDOOR LIGHTING (LANDLORD)			2010	7,380	246	15	246		246	26
27	DRAPES (LANDLORD)			2010	2,817	30	27.5	30		30	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,106,364	$ 130,308		$ 130,308	$	$ 318,215	70

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 181,555	$ 11,419	$ 36,311	$ 24,892	10	$ 76,713	71
72	Current Year Purchases	32,773	22,170	1,639	(20,531)	10	1,639	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		131,279	131,279				74
75	TOTALS	$ 214,328	$ 164,868	$ 169,229	$ 4,361		$ 78,352	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	FACILITY	1996 CHEVY K1500	2009	8,500	2,720	850	(1,870)	5	1,700	77
78	FACILITY	INFINITI G37 CONVERTIBLE	2010	64,255	11,060	6,426	(4,634)	5	6,426	78
79										79
80	TOTALS			$ 72,755	$ 13,780	$ 7,276	$ (6,504)		$ 8,126	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,120,223	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 308,956	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 306,813	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,143)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 404,693	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: $ 18,670 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			890.77	2,672	18
19					19
20					20
21	TOTAL		$ 890.77	$ 2,672	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.

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$		$ 44,012	$		$ 44,012	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			108,113			108,113	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				127,091		127,091	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY,LABORATORY	39-3				12,584			12,584	
	Other (specify): MEDICAL SUPPLIES	39-2					22,354		22,354	13
14	TOTAL			$		$ 164,709	$ 149,445		$ 314,154	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.

STATE OF ILLINOIS

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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	$ 23,917	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,000))	393,646		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	218,601		6
7	Other Prepaid Expenses	1,508		7
8	Accounts Receivable (owners or related parties)	1,191,130		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,828,802	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	4,517		15
16	Equipment, at Historical Cost	245,123		16
17	Accumulated Depreciation (book methods)	(160,588)		17
18	Deferred Charges	22,500		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **develop.costs**	28,086		22
23	Other(specify): **due from mcallister properties**	350,933		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 490,571	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,319,373	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 857,011	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,726		28
29	Short-Term Notes Payable	440,055		29
30	Accrued Salaries Payable	126,650		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,611		31
32	Accrued Real Estate Taxes(Sch.IX-B)	317,527		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,790,580	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	52,717		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)**	$ 52,717	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,843,297	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 476,076	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,319,373	$	48

*(See instructions.)

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 124,760	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(1,267)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 123,493	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	409,401	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	(56,818)	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)**	$ 352,583	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)**	$ 476,076	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,807,128	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,807,128	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,790	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 63,790	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,870,918	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	873,490	31
32	Health Care	1,764,731	32
33	General Administration	1,577,774	33
	B. Capital Expense		
34	Ownership	870,595	34
	C. Ancillary Expense		
35	Special Cost Centers	314,154	35
36	Provider Participation Fee	60,773	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,461,517	40
41	**Income before Income Taxes (line 30 minus line 40)****	409,401	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 409,401	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,150	2,234	$ 86,741	$ 38.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,676	3,732	104,919	28.11	3
4	Licensed Practical Nurses	23,447	24,205	560,198	23.14	4
5	CNAs & Orderlies	55,497	57,523	579,484	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,890	3,131	93,728	29.94	8
9	Activity Director	1,918	2,097	34,933	16.66	9
10	Activity Assistants	6,325	6,803	64,625	9.50	10
11	Social Service Workers	628	639	11,630	18.20	11
12	Dietician					12
13	Food Service Supervisor	2,468	2,669	48,025	17.99	13
14	Head Cook	1,650	1,694	14,344	8.47	14
15	Cook Helpers/Assistants	13,280	14,471	143,849	9.94	15
16	Dishwashers					16
17	Maintenance Workers	1,883	1,927	24,823	12.88	17
18	Housekeepers	334	334	3,343	10.01	18
19	Laundry					19
20	Administrator	2,824	2,840	117,503	41.37	20
21	Assistant Administrator	1,928	1,976	78,926	39.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,618	10,211	149,127	14.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,397	1,524	24,058	15.79	31
32	Other Health C: CARE PLAN	1,635	1,749	59,683	34.12	32
33	Other(specify) MARKETING	26	26	927	35.65	33
34	TOTAL (lines 1 - 33)	133,574	139,785	$ 2,200,866 *	$ 15.74	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	16,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	4,700	10-3	38
39	Pharmacist Consultant	H	1,770	10-3	39
40	Physical Therapy Consultant	L	2,800	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		2,830	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) Nursing Program	S	1,444	10-3	46
47	Dental		3,871	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 33,615		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ATKIN, ELISHA	ADMINISTRATOR	0	$ 103,403
ATKIN, JOEL	ADMINISTRATOR	44	14,100
WAGNER,GERALDINE	ASST ADMIN	0	78,926
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 196,429

B. Administrative - Other

Description		Amount
YAEL ATKIN	MANAGEMENT FEES	$ 119,006
DONNA ATKIN	MANAGEMENT FEES	119,006
TOTAL (agree to Schedule V, line 17, col. 3)		$ 238,012
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		90,917
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 90,917

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,753
Unemployment Compensation Insurance	54,477
FICA Taxes	168,519
Employee Health Insurance	109,759
Employee Meals	14,418
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,469
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	19,050
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	70,299
INSURANCE - EXECUTIVE LIFE VI 21	(70,299)
TOTAL (agree to Schedule V, line 22, col.8)	$ 431,445

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	972
Health Care Worker Background Check	500
(Indicate # of checks performed 50)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	58,062
MARKETING/ADV/PROMO	8,598
LICENSES/DUES/SUBSCRIPTIONS	4,136
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(58,062)
Less: Public Relations Expense	(913)
Non-allowable advertising	(7,685)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,598

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	785
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 785

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MCALLISTER NURSING AND REHAB # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							N/A						
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MCALLISTER NURSING AND REHAB **#** 0049502 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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? **NO**
If YES, give association name and amount.

(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?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

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

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,773**
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. $ **14,418** 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 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.