

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0046276</u></p> <p>Facility Name: <u>Metropolis Nursing & Rehab Center</u></p> <p>Address: <u>2299 Metropolis Street</u> <u>Metropolis</u> <u>62960</u> Number City Zip Code</p> <p>County: <u>Massac</u></p> <p>Telephone Number: <u>618-524-2634</u> Fax # <u>618-524-2507</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/1965</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael Freeman</u> Telephone Number: <u>225 301 2510</u> Email Address: <u>mfreeman@thefreemangroupaccounting.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2010</u> to <u>12/31/2010</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Michael Freeman Managing Director</u> (Firm Name & Address) <u>TFG Consulting, LLC 2198 St. Andrews, Zachary, LA 70791</u> (Telephone) <u>225 301 2510</u> Fax # () _____</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Michael Freeman Managing Director</u> (Firm Name & Address) <u>TFG Consulting, LLC 2198 St. Andrews, Zachary, LA 70791</u> (Telephone) <u>225 301 2510</u> Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number Metropolis Nursing & Rehab Center

0046276 Report Period Beginning: 1/1/2010 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	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	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,612	8,654	5,446	28,712	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,612	8,654	5,446	28,712	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.50%

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

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 _____

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

YES Date _____ NO

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

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

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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

Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

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 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	174,305	17,598	13,543	205,446		205,446	(722)	204,724		1
2	Food Purchase		162,865		162,865		162,865		162,865		2
3	Housekeeping		16,841	84,739	101,580		101,580		101,580		3
4	Laundry		10,137	55,255	65,392		65,392		65,392		4
5	Heat and Other Utilities			169,614	169,614		169,614		169,614		5
6	Maintenance	54,666	18,276	67,586	140,528		140,528		140,528		6
7	Other (specify):*										7
8	TOTAL General Services	228,971	225,717	390,737	845,425		845,425	(722)	844,703		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,196,679	61,696	32,331	1,290,706		1,290,706		1,290,706		10
10a	Therapy		1,538	591,208	592,746		592,746		592,746		10a
11	Activities	43,547	864	11,715	56,126		56,126		56,126		11
12	Social Services	81,980	261	5,317	87,558		87,558		87,558		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,322,206	64,359	640,571	2,027,136		2,027,136		2,027,136		16
	C. General Administration										
17	Administrative	70,593			70,593		70,593		70,593		17
18	Directors Fees										18
19	Professional Services			425,132	425,132		425,132	(365,346)	59,786		19
20	Dues, Fees, Subscriptions & Promotions			19,780	19,780		19,780		19,780		20
21	Clerical & General Office Expenses	85,895	22,247	73,865	182,007		182,007	183,123	365,130		21
22	Employee Benefits & Payroll Taxes			269,035	269,035		269,035		269,035		22
23	Inservice Training & Education			56	56		56		56		23
24	Travel and Seminar			21,508	21,508		21,508		21,508		24
25	Other Admin. Staff Transportation			12,178	12,178		12,178		12,178		25
26	Insurance-Prop.Liab.Malpractice			46,957	46,957		46,957		46,957		26
27	Other (specify):*										27
28	TOTAL General Administration	156,488	22,247	868,511	1,047,246		1,047,246	(182,223)	865,023		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,707,665	312,323	1,899,819	3,919,807		3,919,807	(182,945)	3,736,862		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 Number

Metropolis Nursing & Rehab Center

#0046276

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			32,169	32,169		32,169	98,770	130,939			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							192,085	192,085			32
33	Real Estate Taxes			44,254	44,254		44,254		44,254			33
34	Rent-Facility & Grounds			277,580	277,580		277,580	(271,801)	5,779			34
35	Rent-Equipment & Vehicles			15,649	15,649		15,649	7,161	22,810			35
36	Other (specify):*											36
37	TOTAL Ownership			369,652	369,652		369,652	26,215	395,867			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			384	384		384		384			38
39	Ancillary Service Centers		240,317	5,690	246,007		246,007		246,007			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,643	56,643		56,643		56,643			42
43	Other (specify):* See Attached Groupings		7,083	51,947	59,030		59,030	(39,538)	19,492			43
44	TOTAL Special Cost Centers		247,400	114,664	362,064		362,064	(39,538)	322,526			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,707,665	559,723	2,384,135	4,651,523		4,651,523	(196,268)	4,455,255			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 Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(722)	1		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				9
10	Interest and Other Investment Income				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	(21,710)	21		18
19	Entertainment	(7,565)	21		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	(39,538)	43		24
25	Fund Raising, Advertising and Promotional	(38,899)	19		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (108,434)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (108,434)		37

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

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

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

ID# 0046276
Report Period Beginning: 1/1/2010
Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
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30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Metropolis Nursing & Rehab Center# 0046276 Report Period Beginning:

1/1/2010

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(722)	0	0	0	0	0	0	0	0	0	0	(722)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(722)	0	0	0	0	0	0	0	0	0	0	(722)	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	(38,899)	(326,447)	0	0	0	0	0	0	0	0	0	(365,346)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(29,275)	212,398	0	0	0	0	0	0	0	0	0	183,123	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(68,174)	(114,049)	0	0	0	0	0	0	0	0	0	(182,223)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(68,896)	(114,049)	0	0	0	0	0	0	0	0	0	(182,945)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Metropolis Nursing & Rehab Center# 0046276

Report Period Beginning:

1/1/2010 Ending:

12/31/2010

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	98,770	0	0	0	0	0	0	0	0	0	98,770	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	192,085	0	0	0	0	0	0	0	0	0	192,085	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(271,801)	0	0	0	0	0	0	0	0	0	(271,801)	34
35	Rent-Equipment & Vehicles	0	7,161	0	0	0	0	0	0	0	0	0	7,161	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	26,215	0	0	0	0	0	0	0	0	0	26,215	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):*	(39,538)	0	0	0	0	0	0	0	0	0	0	(39,538)	43
44	TOTAL Special Cost Centers	(39,538)	0	0	0	0	0	0	0	0	0	0	(39,538)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(108,434)	(87,834)	0	0	0	0	0	0	0	0	0	(196,268)	45

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
Walnut Creek Management	100					
TI Metropolis, LLC - Bldg Owner	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Buildings & Fixtures	\$	Walnut Creek Mgt Co, LLC	100.00%	\$ 5,779	\$	5,779	1
2	V	35 Moveable Equip		Walnut Creek Mgt Co, LLC	100.00%	7,161		7,161	2
3	V	21 Non-Capital		Walnut Creek Mgt Co, LLC	100.00%	186,522		186,522	3
4	V	34 Rent	277,580	TI Metropolis, LLC	100.00%			(277,580)	4
5	V	30 Depreciation		TI Metropolis, LLC	100.00%	98,770		98,770	5
6	V	32 Interest		TI Metropolis, LLC	100.00%	192,085		192,085	6
7	V	21 A&G		TI Metropolis, LLC	100.00%	25,876		25,876	7
8	V	19 Management Fees	326,447	Walnut Creek Mgt Co, LLC	100.00%			(326,447)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 604,027			\$ 516,193	\$ *	(87,834)	14

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

Facility Name & ID Number

Metropolis Nursing & Rehab Center

#

0046276

Report Period Beginning:

1/1/2010

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 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 Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

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 NO

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

Name of Related Organization Tutera Health Care Services Consolidated
 Street Address 7611 State Line Rd, Suite 301
 City / State / Zip Code Kansas City, MO
 Phone Number (8164440900
 Fax Number (8164440900

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Non-Capital	Direct Costs	160,162,283	26	\$ 6,881,683	\$ 4,341,058	\$ 186,522	1
2	34	Capital Building	Direct Costs	160,162,283	26	213,212	4,341,058	5,779	2
3	35	Capital Equipment	Direct Costs	160,162,283	26	264,205	4,341,058	7,161	3
4	30	Depreciation	Direct Costs						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					\$ 7,359,100	\$	\$ 199,462	25

Facility Name & ID Number Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

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										
										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	NA																		
2																			
3																			
4																			
5																			
Working Capital																			
6																			
7																			
8																			
9	TOTAL Facility Related																		
B. Non-Facility Related*																			
10																			
11																			
12																			
13																			
14	TOTAL Non-Facility Related																		
15	TOTALS (line 9+line14)																		

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	86,032	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.)		\$	44,254	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(41,778)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	86,032	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	44,254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	74,667	8
	2006	66,038	9
	2007	42,493	10
	2008	43,403	11
	2009	44,254	12

The 2010 amount was based upon 2009 accrual amounts

	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 Metropolis Nursing & Rehab Center COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0046276

CONTACT PERSON REGARDING THIS REPORT Michael Freeman

TELEPHONE 2253012510 FAX #: ()

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-36-300-066</u>	<u>Land</u>	\$ <u>44,254.00</u>	\$ <u>44,254.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>44,254.00</u>	\$ <u>44,254.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,793 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>42,793</u>	<u>2003</u>	<u>\$ 285,485</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>42,793</u>		<u>\$ 285,485</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	92		2003	1965	\$ 2,226,786	\$ 58,490	40	\$ 58,490		\$ 423,164	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic door closures (7)		2003		1,185	79	15	79		579	9
10	Chemical monitor for chiller		2003		1,684		5			1,684	10
11	Door kickplates		2004		4,898	490	10	490		3,265	11
12	Nurses station		2004		4,090	273	15	273		1,795	12
13	50 Ton chiller		2004		34,400	1,720	20	1,720		10,607	13
14	Versico roofing system		2005		29,700	2,970	10	2,970		16,583	14
15	Remodel		2005		113,689	11,369	10	11,369		60,634	15
16	Painting bedrooms and bathrooms		2005		9,055	1,207	5	1,207		9,054	16
17	Carpet front entrance & back patio		2006		2,795	559	5	559		2,469	17
18	Nurse call system		2007		2,132	426	5	426		1,528	18
19	VINYL FLOORING		2010		25,038	1,252	10	1,252		1,252	19
20	CARPET		2010		7,599	887	5	887		887	20
21	BLINDS, PRIVACY CURTAINS, WINDOW TREATMENTS		2010		28,448	2,845	5	2,845		2,845	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

*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 Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	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)	\$	2,491,499	\$	82,567	\$	82,567	\$	536,346	70

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

Facility Name & ID Number Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

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	\$ 109,170	\$ 8,093	\$ 8,093	\$		\$ 70,482	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 109,170	\$ 8,093	\$ 8,093	\$		\$ 70,482	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										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,886,154	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 90,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 90,660	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 606,828	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ _____ Description: YES NO Equipment Rental in GL 7170

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					Units	Cost										
1	Licensed Occupational Therapist	10a column 3	hrs	\$	3,067	\$ 198,727						3,067	\$ 198,727			1
2	Licensed Speech and Language Development Therapist	10a column 3	hrs		1,093	70,847						1,093	70,847			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a column 3	hrs		4,964	321,634			1,538			4,964	323,172			4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$	9,124	\$ 591,208			1,538			9,124	\$ 592,746			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.

Facility Name & ID Number Metropolis Nursing & Rehab Center# 0046276Report Period Beginning: 1/1/2010

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	\$ 38,669	\$	1
2	Cash-Patient Deposits	27,516		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	313,123		3
4	Supply Inventory (priced at <u>LCM</u>)	14,758		4
5	Short-Term Investments			5
6	Prepaid Insurance	(22,399)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from LOC Lender</u>	149,372		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 521,039	\$	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	203,626		15
16	Equipment, at Historical Cost	109,170		16
17	Accumulated Depreciation (book methods)	(183,663)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 129,133	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 650,172	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 486,438	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,109		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,306		30
31	Accrued Taxes Payable (excluding real estate taxes)	91,069		31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,932		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)	\$ 738,854	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Rounding Adjustment</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 738,854	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (88,682)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 650,172	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 264,121	1
2	Restatements (describe):		2
3	Prior Period Adjustments	450,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 714,121	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	372,197	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	50,000	9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,225,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (802,803)	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)	\$ (88,682)	24 *

* This must agree with page 17, line 47.

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,115,703	1
2	Discounts and Allowances for all Levels	(471,817)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,643,886	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,955,755	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,955,755	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	2,324	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	722	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	395,335	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,687	19
20	Radiology and X-Ray		20
21	Other Medical Services	9,973	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 422,041	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	466	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 466	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Income/PPA</u>	1,572	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,572	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,023,720	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	845,425	31
32	Health Care	2,027,136	32
33	General Administration	1,047,246	33
B. Capital Expense			
34	Ownership	369,652	34
C. Ancillary Expense			
35	Special Cost Centers	305,421	35
36	Provider Participation Fee	56,643	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,651,523	40
41	Income before Income Taxes (line 30 minus line 40)**	372,197	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 372,197	43

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

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

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

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

Facility Name & ID Number Metropolis Nursing & Rehab Center

0046276

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	9,106	9,830	\$ 201,459	\$ 20.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,648	5,805	119,041	20.51	3
4	Licensed Practical Nurses	17,705	18,715	323,503	17.29	4
5	CNAs & Orderlies	55,204	57,181	533,478	9.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,666	3,867	43,547	11.26	10
11	Social Service Workers	4,763	5,069	81,980	16.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,573	18,135	174,305	9.61	15
16	Dishwashers					16
17	Maintenance Workers	3,697	3,882	54,666	14.08	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,096	2,288	74,792	32.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,752	6,212	81,220	13.07	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	911	983	9,318	9.48	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Inventary Included</u>	729	801	10,356	12.93	33
34	TOTAL (lines 1 - 33)	126,850	132,768	\$ 1,707,665 *	\$ 12.86	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Scott Scout	Administrator		\$ 70,593	Workers' Compensation Insurance	\$ 66,363	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	17,565	
				FICA Taxes	150,138	Health Care Worker Background Check		
				Employee Health Insurance	52,149	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Deus and Subscriptions	1,939	
				Other Benefits	385	Licenses	276	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,593	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other						Less: Public Relations Expense ()		
Description			Amount			Non-allowable advertising ()		
None			\$			Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Walnut Creek Management	Management Fees	\$ 326,447			\$	Out-of-State Travel	\$	
See Attached	Legal Fees	3,351						
BKD, LLP	Accounting Fees	13,761				In-State Travel	21,508	
Galazy/E Health Services	Data Processing Fees	40,858						
Pinnacle Consulting	Professional Services	1,816				Seminar Expense		
Yellow Pages/Various	Advertising & Pr Other	38,899						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 425,132	TOTAL		Entertainment Expense () (agree to Sch. V, line 24, col. 8)	\$ 21,508	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Metropolis Nursing & Rehab Center

Report Period Beginning: 1/1/2010 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? 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? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 98
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (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. \$ 56,643
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? Yes Indicate the amount. \$ 722
- (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. \$ NA
 - c. What percent of all travel expense relates to transportation of nurses and patients? NA
 - d. Have vehicle usage logs been maintained? NA
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
 - 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. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: NA
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.