		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.

I. IDPH License ID Number: 0047126

Facility Name: St Anthony's Nursing & Rehab Center

Address: 767 30th Street (Number) Rock Island (City) 61201 (Zip Code)

County: Rock Island

Telephone Number: (309) 788-7631 **Fax #** (309) 788-9823

HFS ID Number:

Date of Initial License for Current Owners: 5/19/05

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: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address: mike.martin@mcgladrey.com

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)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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 N/A

	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	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,390	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	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	604	738	4,495	5,837	8
9	SNF/PED					9
10	ICF	27,574	2,934		30,508	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,178	3,672	4,495	36,345	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.60%

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

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

I. On what date did you start providing long term care at this location?
Date started 05/19/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/19/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 44 and days of care provided 2,618

Medicare Intermediary National Government Services

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	219,716	18,144	4,473	242,333		242,333		242,333			1
2	Food Purchase		193,089		193,089		193,089		193,089			2
3	Housekeeping	153,930	31,972		185,902		185,902		185,902			3
4	Laundry	56,873	40,747		97,620		97,620		97,620			4
5	Heat and Other Utilities			268,795	268,795		268,795	884	269,679			5
6	Maintenance	162,814		77,177	239,991		239,991		239,991			6
7	Other (specify):*											7
8	**TOTAL General Services**	593,333	283,952	350,445	1,227,730		1,227,730	884	1,228,614			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,940,786	65,807	6,086	2,012,679		2,012,679	245,036	2,257,715			10
10a	Therapy			359,686	359,686		359,686		359,686			10a
11	Activities	48,060	4,752	244	53,056		53,056		53,056			11
12	Social Services	33,402		1,369	34,771		34,771		34,771			12
13	CNA Training											13
14	Program Transportation			307	307		307		307			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,022,248	70,559	389,292	2,482,099		2,482,099	245,036	2,727,135			16
	C. General Administration											
17	Administrative	90,867		268,160	359,027		359,027	(268,160)	90,867			17
18	Directors Fees											18
19	Professional Services			46,161	46,161		46,161	29,293	75,454			19
20	Dues, Fees, Subscriptions & Promotions			17,805	17,805		17,805	1,712	19,517			20
21	Clerical & General Office Expenses	104,926	2,876	32,980	140,782		140,782	7,109	147,891			21
22	Employee Benefits & Payroll Taxes			301,148	301,148		301,148		301,148			22
23	Inservice Training & Education							261	261			23
24	Travel and Seminar			1,939	1,939		1,939	31,525	33,464			24
25	Other Admin. Staff Transportation			4,611	4,611		4,611	1,328	5,939			25
26	Insurance-Prop.Liab.Malpractice			75,407	75,407		75,407	1,903	77,310			26
27	Other (specify):* **Mgmt-EE Benefits**							27,278	27,278			27
28	**TOTAL General Administration**	195,793	2,876	748,211	946,880		946,880	(167,751)	779,129			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,811,374	357,387	1,487,948	4,656,709		4,656,709	78,169	4,734,878			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 St Anthony's Nursing & Rehab Center #0047126 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			15,167	15,167		15,167	86,555	101,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,533	52,533		52,533	(19,528)	33,005			32
33	Real Estate Taxes			81,751	81,751		81,751		81,751			33
34	Rent-Facility & Grounds			173,800	173,800		173,800	(165,278)	8,522			34
35	Rent-Equipment & Vehicles			22,110	22,110		22,110	1,621	23,731			35
36	Other (specify):*											36
37	TOTAL Ownership			345,361	345,361		345,361	(96,630)	248,731			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		220,259		220,259		220,259		220,259			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,175	71,175		71,175		71,175			42
43	Other (specify):* Non-Allowable Cos	46,417		614,533	660,950		660,950	(660,950)				43
44	TOTAL Special Cost Centers	46,417	220,259	685,708	952,384		952,384	(660,950)	291,434			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,857,791	577,646	2,519,017	5,954,454		5,954,454	(679,411)	5,275,043			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	(2,358)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(28,748)	30		9
10	Interest and Other Investment Income	(21,244)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(564,492)	43		24
25	Fund Raising, Advertising and Promotional	(1,972)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(102,568)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (721,382)		$	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)	41,971		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,971		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (679,411)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

St Anthony's Nursing & Rehab Center

ID# 0047126

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (46,417)	43	1
2	Labs - Part A	(9,178)	43	2
3	X-Rays - Part A	(2,978)	43	3
4	Penalties	(29,221)	43	4
5	Non-allowable legal	750	19	5
6	Other Services - Medicare	(2,834)	43	6
7	Offset Goodwill Amort.	(6,163)	31	7
8	Misc Income Facility	(5,027)	21	8
9	Political Contributions	(1,500)	43	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**	(102,568)		49

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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
Suzanne Koenig	90%	See Schedule 6A		See Schedule 6B		
Gary Weintraub	10%	See Schedule 6A				
				St. Anthony's Property Partners		Building Company

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		21	Clerical - Other	$	St. Anthony's Property Partners	100.00%	$ 1,116	$ 1,116	1
2	V		30	Depreciation		St. Anthony's Property Partners	100.00%	114,000	114,000	2
3	V		31	Amortization		St. Anthony's Property Partners	100.00%	6,163	6,163	3
4	V		34	Rent- Facility & Grounds	173,800	St. Anthony's Property Partners	100.00%		(173,800)	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				$ 173,800			$ 121,279	$ * (52,521)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Related Nursing Homes **Schedule 6A**

As of 12/31/10

Group Name	Facility Name	City
SAK Management	Lena Living Center	Lena
	The Lincoln Home	Belleville
	St. Anthony's Nursing & Rehab Ctr	Rock Island
	Thornton Heights Terrace	Chicago Heights
	Parkview Terrace	East Moline

See Accountants' Compilation Report

Other Related Business Entities **Schedule 6B**

As of 12/31/09

Name	City	Type of Business
SAK Management Services	Chicago	Management Company

See Accountants' Compilation Report

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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. [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)	
15	V	5	Utilities	$	SAK Management Services, LLC	90.00%	$ 884	$ 884	15
16	V	10	Nursing - Salaries		SAK Management Services, LLC	90.00%	245,036	245,036	16
17	V	17	Administrative - Salaries	268,160	SAK Management Services, LLC	90.00%	0	(268,160)	17
18	V	19	Professional Fees		SAK Management Services, LLC	90.00%	28,543	28,543	18
19	V	20	Dues,Fees & Subs		SAK Management Services, LLC	90.00%	1,712	1,712	19
20	V	21	Clerical		SAK Management Services, LLC	90.00%	11,020	11,020	20
21	V	23	Training/Education		SAK Management Services, LLC	90.00%	261	261	21
22	V	24	Travel/Seminar		SAK Management Services, LLC	90.00%	31,525	31,525	22
23	V	25	Other Admin. Transp		SAK Management Services, LLC	90.00%	1,328	1,328	23
24	V	26	Insurance - Prop/Liability		SAK Management Services, LLC	90.00%	1,903	1,903	24
25	V	27	EE Benefits		SAK Management Services, LLC	90.00%	27,278	27,278	25
26	V	30	Depreciation Expense		SAK Management Services, LLC	90.00%	1,303	1,303	26
27	V	32	Interest		SAK Management Services, LLC	90.00%	1,716	1,716	27
28	V	34	Rent - Facility & Grounds		SAK Management Services, LLC	90.00%	8,522	8,522	28
29	V	35	Rent - Eqpt. & Vehicles		SAK Management Services, LLC	90.00%	1,621	1,621	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			$ 268,160			$ 362,652	$ * 94,492	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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 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									$		1
2	N/A										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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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: SAK Management Services
Street Address: 4055 W. Peterson, Suite 101
City / State / Zip Code: Chicago, IL 60646
Phone Number: ((773) 202-0000
Fax Number: ((773) 267-0111

	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	5	Utilities	SAK Management Fees	1,673,164	16	$ 5,514	$	268,160	$ 884	1
2	10	Nursing - Salaries	SAK Management Fees	1,673,164	16	1,528,886	1,528,886	268,160	245,036	2
3	17	Administrative - Salaries	SAK Management Fees	1,673,164	16	0		268,160	0	3
4	19	Professional Fees	SAK Management Fees	1,673,164	16	178,094		268,160	28,543	4
5	20	Dues,Fees & Subs	SAK Management Fees	1,673,164	16	10,680		268,160	1,712	5
6	21	Clerical	SAK Management Fees	1,673,164	16	68,758		268,160	11,020	6
7	23	Training/Education	SAK Management Fees	1,673,164	16	1,630		268,160	261	7
8	24	Travel/Seminar	SAK Management Fees	1,673,164	16	199,549		268,160	31,982	8
9	25	Other Admin. Transp	SAK Management Fees	1,673,164	16	8,286		268,160	1,328	9
10	26	Insurance - Prop/Liability	SAK Management Fees	1,673,164	16	11,874		268,160	1,903	10
11	27	EE Benefits	SAK Management Fees	1,673,164	16	170,199		268,160	27,278	11
12	30	Depreciation Expense	SAK Management Fees	1,673,164	16	8,130		268,160	1,303	12
13	34	Rent - Facility & Grounds	SAK Management Fees	1,673,164	16	53,174		268,160	8,522	13
14	35	Rent - Eqpt. & Vehicles	SAK Management Fees	1,673,164	16	10,117		268,160	1,621	14
15	43	Other	SAK Management Fees	1,673,164	16	0		268,160	0	15
16	32	Interest	SAK Management Fees	1,673,164	16	10,705		268,160	1,716	16
17										17
18	24	Travel/Seminar	Direct	225,034					(457)	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,265,595	$ 1,528,886		$ 362,652	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	HUD		X	Mortgage		12/17/2009	$ 11,955,400	$ 11,955,400	12/18/2047	6.7500	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Cole Taylor Bank		X	LOC				325,414	11/30/2010	6.0000	24,566	6
7	SAK Management	X		Working Capital		12/17/2009	186,449	186,449	12/17/2010	15.0000	27,967	7
8	Suzanna A Koenig	X		Working Capital			163,386	169,386				8
9	TOTAL Facility Related						$ 12,305,235	$ 12,636,649			$ 52,533	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(21,244)	12
13								Allocation from Mgmt Co.			1,716	13
14	TOTAL Non-Facility Related						$	$			$ (19,528)	14
15	TOTALS (line 9+line14)						$ 12,305,235	$ 12,636,649			$ 33,005	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 St Anthony's Nursing & Rehab Center # 0047126 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.**		$ 23,239	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.)	2009	$ 75,291	2
3. Under or (over) accrual (line 2 minus line 1).		$ 52,052	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 27,726	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
	Unreconciled Difference	1,973	
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.		$ 81,751	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	70,072	8
	2006	69,864	9
	2007	71,793	10
	2008	76,109	11
	2009	75,291	12

Accrual is based on prior year Real Estate Tax Bills adjusted in the current year for estimated inflation.

	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Anthony's Nursing & Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Suzanne Koenig

TELEPHONE (773) 202-0000 FAX #: (733)267-0111

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.	09-231-19-00	Long Term Care Property	$ 1,415.36	$ 1,415.36
2.	09-175-06-00	Long Term Care Property	$ 73,875.36	$ 73,875.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,290.72	$ 75,290.72

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 St Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 149,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 5

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	319,300	2005	$ 150,000	1
2					2
3	TOTALS	319,300		$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	140		2005	1974	$ 2,050,000	$	35	$ 58,571	$ 58,571	$ 351,426	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security & Monitoring System			2005	3,522		20	176	176	1,208	9
10	Boiler			2005	24,087		10	2,409	2,409	13,250	10
11	Boiler repairs			2008	18,233	3,189	7	2,604	(585)	6,510	11
12	Heater System Reapair			2009	4,635	1,135	7	662	(473)	1,324	12
13	Boiler Repairs			2010	22,384	3,199	7	1,599	(1,600)	1,599	13
14											14
15											15
16											16
17	Adjust depreciation to financials					(1,018)			1,018		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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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)		$ 2,122,861	$ 6,505		$ 66,021	$ 59,516	$ 375,317	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	$ 318,943	$ 5,956	$ 32,627	$ 26,671	10	$ 193,033	71
72	Current Year Purchases	11,925	1,837	919	(918)		919	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.			1,303	1,303			74
75	TOTALS	$ 330,868	$ 7,793	$ 34,849	$ 27,056		$ 193,952	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	Facility	Ford Winstar	2005	$ 1,506	$ 135	$ 302	$ 167	5	$ 1,510	76
77	Facility	Snow Plow Truck	2010	5,500	734	550	(184)	5	550	77
78										78
79										79
80	TOTALS			$ 7,006	$ 869	$ 852	$ (17)		$ 2,060	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)	$ 2,610,735	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,167	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,722	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 86,555	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 571,329	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	N/A	$	$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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
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:				$ N/A			3
4	Additions							4
5								5
6		Allocated from Management Co.			8,522			6
7	TOTAL				$ 8,522 **			7

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

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

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	$

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: $ 23,731 Description: See Sch 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

16.

Description	*Amount*
Transmission Rental	2,045
Copier Rental	8,100
Postage Meter Rental	1,723
Concentrator Rentals	2,964
Nursing Supplies Rental	7,278
Home Office Allcoation	1,621
Total	23,731

See Accountants' Compilation Report

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,192	$ 151,239	$	2,192	$ 151,239	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		699	48,264		699	48,264	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,322	160,185		2,322	160,185	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				179,853		179,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					40,406		40,406	12
13	Other (specify):									13
14	TOTAL			$	5,213	$ 359,688	$ 220,259	5,213	$ 579,947	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	$ 1,938	$ 25,163	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 931,492)	448,391	448,391	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	68,921	68,921	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	353,383	2,372,231	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 872,633	$ 2,914,706	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,050,000	14
15	Leasehold Improvements, at Historical Cost	12,511	72,861	15
16	Equipment, at Historical Cost	118,220	337,874	16
17	Accumulated Depreciation (book methods)	(59,345)	(571,329)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		92,500	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(34,937)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See. Sch 17A		6,346,862	22
23	Other(specify): Security Deposits	65,153	65,153	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 136,539	$ 8,508,984	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,009,172	$ 11,423,690	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,771,772	$ 1,856,914	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	681,249	681,249	29
30	Accrued Salaries Payable	133,175	133,175	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		27,726	32
33	Accrued Interest Payable		56,789	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	1,701,567	11,024	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,287,763	$ 2,766,877	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,955,400	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)**	$	$ 11,955,400	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,287,763	$ 14,722,277	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,278,591)	$ (3,298,587)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,009,172	$ 11,423,690	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

St Anthony's Nursing & Rehab Center
Provider #: 0047126
01/01/10 - 12/31/10

Schedule 17A

XV. Balance Sheet

Line 9 - Other Current Assets (specify)	Operating	After Consolidation
Construction Escrow	-	1,844,061
Loan Issuance Costs	-	174,787
Due from Medicare	44,758.00	44,758
Re-Capitalization Escrow	309,942.00	309,942
Iowa State Withholding	(1,317)	(1,317)
Total Line 9 - Other Current Assets	353,383	2,372,231

Line 22 - Other Long Term Assets (specify)		
RE-Construction Reserve-C.T.	-	5,688
RE-Construction in Process	-	6,341,174
Total Line 22 - Other Long Term Assets	-	6,346,862

Line 36 - Other Current Liabilities (specify)		
Due from St. Anthony's Nsg & Rehab	-	1,690,543
Due to DPA	(269)	(269)
Federal Withholding Taxes	(4,311)	(4,311)
SS & Medicare Withholding Taxes	(6,444)	(6,444)
Due to St. Anthony Prop. LLC	(1,690,543)	(1,690,543)
Total Line 36 - Other Current Liabilities	(1,701,567)	(11,024)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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**	$ (2,125,236)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(334,426)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,459,662)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(818,929)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (818,929)	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)**	$ (3,278,591)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	$ 4,517,862	1
2	Discounts and Allowances for all Levels	(525,121)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,992,741	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	969,547	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 969,547	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	167,516	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	570	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 168,086	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	124	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 124	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,027	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,027	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,135,525	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,227,730	31
32	Health Care	2,482,099	32
33	General Administration	946,880	33
	B. Capital Expense		
34	Ownership	345,361	34
	C. Ancillary Expense		
35	Special Cost Centers	881,209	35
36	Provider Participation Fee	71,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,954,454	40
41	**Income before Income Taxes (line 30 minus line 40)****	(818,929)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (818,929)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
****LLC members are cash basis tax payers.**

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

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

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	2,024	2,080	$ 64,152	$ 30.84	1
2	Assistant Director of Nursing	2,016	2,160	48,031	22.24	2
3	Registered Nurses	10,638	11,334	265,659	23.44	3
4	Licensed Practical Nurses	24,660	26,243	474,092	18.07	4
5	CNAs & Orderlies	88,985	94,647	1,018,848	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,547	5,210	48,060	9.22	9
10	Activity Assistants					10
11	Social Service Workers	1,920	1,974	33,402	16.92	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,120	45,443	21.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,756	19,405	174,273	8.98	15
16	Dishwashers					16
17	Maintenance Workers	11,489	12,230	162,814	13.31	17
18	Housekeepers	17,153	19,067	153,930	8.07	18
19	Laundry	5,728	6,100	56,873	9.32	19
20	Administrator	1,960	2,080	90,867	43.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,549	7,003	104,926	14.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care Plan Coord	1,974	2,086	70,004	33.56	32
33	Other(specify) Marketing	1,988	2,092	46,417	22.19	33
34	TOTAL (lines 1 - 33)	201,323	215,831	$ 2,857,791 *	$ 13.24	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	112	$ 4,473	1(3)	35
36	Medical Director	120	21,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	116	5,826	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	260	10(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	244	11(3)	44
45	Social Service Consultant	55	1,369	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	418	$ 33,772		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Hufsey	Administrator	0	$ 90,867
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,867

B. Administrative - Other

Description	Amount
Management Fees "Eliminated in Col. 7"	$ 268,160
TOTAL (agree to Schedule V, line 17, col. 3)	$ 268,160
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21A		$ 46,161
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 46,161

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,579
Unemployment Compensation Insurance	33,909
FICA Taxes	179,071
Employee Health Insurance	33,770
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	369
Other Employee Benefits	2,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 301,148

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 140)	1,680
Patient Background Checks 79	950
Background Check-Chargebacks	130
Illinois Council on Long Term Care	11,856
Quad Cities Chamber of Commerce	700
Miscellaneous License & Fees	2,489
Allocation from Mgmt Co.	1,712
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,517

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,939
Allocation From Mgmt. Co.	31,525
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,464

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

St Anthony's Nursing & Rehab Center
Provider #: 0047126
01/01/10 - 12/31/10

Schedule 21A

XIX.C. Professional Services

Vendor/Payee	Type	Amount	
Aronberg Goldgehn Davis & Garmisa	Legal Fees	338	
Shaw Gussis Fishman Glanz Wolfson & To	Legal Fees	6215	
McGladrey	Cost Report Prep	9017	
McGladrey	Tax Return Prep	4167	
Sharon Haugh Lofgren	Medicare Billing	3600	
Personnal Planners	Unemployment Consulta	840	
Ivans Inc.	Data Processing	2039.5	
Payday-USA	Data Processing	4383.4	
Health Data Systems Inc.	Data Processing	6462.5	
LTC Solutions Inc.	Data Processing	1800	
Alpha Data Services LLC	Data Processing	-20	
ADP	Data Processing	250	
Emdeon Business Services-Medifax	Data Processing	19	
Richard Peelo & Associates Inc.	Medicare Consultant	4,200	
Midwest Renovation & Restoration Inc.	Consultant	2,205	
Kay Wallin- Consulting	Consultant	645	
	Total	46,161	To PG21

Total for Page 3, Line 19, Column 3	46,161
Additional Legal Fees	750
Allocation from Mgmt. Co.	28,543
Total for Page 3, Line 19, Column 8	75,454

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $11,856**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,732** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **71,175**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.