

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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>0051003</u></p> <p>Facility Name: <u>Cobden Rehabilitation and Nursing Center, LLC</u></p> <p>Address: <u>430 South Front Street</u> <u>Cobden</u> <u>62920</u> <small>Number City Zip Code</small></p> <p>County: <u>Union County</u></p> <p>Telephone Number: <u>(708) 236-0000</u> Fax # <u>(708) 236-0001</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>06/01/10</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dan Gaafar</u> Telephone Number: <u>(317) 237-5503</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>01/01/2011</u> to <u>12/31/2011</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Steven Blisko</u> (Title) <u>Manager</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>See Accountants' Compilation Report Attached</u> (Print Name and Title) <u>Dan Gaafar Partner</u> (Firm Name & Address) <u>Bradley Associates 201 S. Capital Ave, Suite 910, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></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) <u>Steven Blisko</u> (Title) <u>Manager</u>	Paid Preparer	(Signed) <u>See Accountants' Compilation Report Attached</u> (Print Name and Title) <u>Dan Gaafar Partner</u> (Firm Name & Address) <u>Bradley Associates 201 S. Capital Ave, Suite 910, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Steven Blisko</u> (Title) <u>Manager</u>							
Paid Preparer	(Signed) <u>See Accountants' Compilation Report Attached</u> (Print Name and Title) <u>Dan Gaafar Partner</u> (Firm Name & Address) <u>Bradley Associates 201 S. Capital Ave, Suite 910, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cobden Rehabilitation and Nursing Center, LLC

0051003 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	16	Skilled (SNF)	16	5,840	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	3,421	283	884	4,587	8
9	SNF/PED					9
10	ICF	12,399	1,024	3,203	16,627	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,820	1,307	4,087	21,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.54%

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)
N/A

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 06/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/10 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 10 and days of care provided 1,033

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Cobden Rehabilitation and Nursing Center, I # 0051003 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	112,097	7,121	4,607	123,825		123,825	(33)	123,792		1
2	Food Purchase		106,794		106,794		106,794		106,794		2
3	Housekeeping	95,012	10,087		105,099		105,099		105,099		3
4	Laundry	43,250	4,703		47,953		47,953		47,953		4
5	Heat and Other Utilities			78,712	78,712		78,712	1,800	80,512		5
6	Maintenance	16,406	8,802	15,875	41,083		41,083	9	41,092		6
7	Other (specify):*										7
8	TOTAL General Services	266,765	137,507	99,194	503,466		503,466	1,776	505,242		8
	B. Health Care and Programs										
9	Medical Director			9,245	9,245		9,245		9,245		9
10	Nursing and Medical Records	639,200	67,386	26,017	732,603		732,603	(9,878)	722,725		10
10a	Therapy			151,386	151,386		151,386		151,386		10a
11	Activities	26,407	2,394		28,801		28,801		28,801		11
12	Social Services	35,707		3,091	38,798		38,798		38,798		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consultant			3,052	3,052		3,052		3,052		15
16	TOTAL Health Care and Programs	701,314	69,780	192,791	963,885		963,885	(9,878)	954,007		16
	C. General Administration										
17	Administrative	39,520			39,520		39,520		39,520		17
18	Directors Fees										18
19	Professional Services			133,659	133,659		133,659	(95,933)	37,726		19
20	Dues, Fees, Subscriptions & Promotions			3,464	3,464		3,464	89	3,553		20
21	Clerical & General Office Expenses	26,855	16,449	15,164	58,468		58,468	55,473	113,941		21
22	Employee Benefits & Payroll Taxes			153,287	153,287		153,287	12,483	165,770		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,030	5,030		5,030	3,133	8,163		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			48,317	48,317		48,317	201	48,518		26
27	Other (specify):*										27
28	TOTAL General Administration	66,375	16,449	358,921	441,745		441,745	(24,554)	417,191		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,034,454	223,736	650,906	1,909,096		1,909,096	(32,656)	1,876,440		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 Cobden Rehabilitation and Nursing Center, LLC #0051003 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,976	7,976		7,976	(4,239)	3,737			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			5,974	5,974		5,974	138	6,112			32
33	Real Estate Taxes			27,298	27,298		27,298		27,298			33
34	Rent-Facility & Grounds			415,539	415,539		415,539	2,764	418,303			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			457,602	457,602		457,602	(1,337)	456,265			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			115	115		115		115			38
39	Ancillary Service Centers		78,635		78,635		78,635		78,635			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		78,635	40,630	119,265		119,265		119,265			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,034,454	302,371	1,149,138	2,485,963		2,485,963	(33,993)	2,451,970			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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,052)	30		9
10	Interest and Other Investment Income	(14)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	1		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				24
25	Fund Raising, Advertising and Promotional	(173)	21		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)	\$ (5,272)		\$	30

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)	(28,721)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,721)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (33,993)		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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Cobden Rehabilitation and Nursing Center, LLC

ID# 0051003

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1				1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cobden Rehabilitation and Nursing Center, LLC# 0051003

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	(33)	0	0	0	0	0	0	0	0	0	0	(33)	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	1,800	0	0	0	0	0	0	0	0	0	1,800	5
6	Maintenance	0	9	0	0	0	0	0	0	0	0	0	9	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(33)	1,809	0	0	0	0	0	0	0	0	0	1,776	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	(9,878)	0	0	0	0	0	0	0	0	0	(9,878)	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	(9,878)	0	0	0	0	0	0	0	0	0	(9,878)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(95,933)	0	0	0	0	0	0	0	0	0	(95,933)	19
20	Fees, Subscriptions & Promotions	0	89	0	0	0	0	0	0	0	0	0	89	20
21	Clerical & General Office Expenses	(173)	51,596	4,050	0	0	0	0	0	0	0	0	55,473	21
22	Employee Benefits & Payroll Taxes	0	12,483	0	0	0	0	0	0	0	0	0	12,483	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,133	0	0	0	0	0	0	0	0	0	3,133	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	201	0	0	0	0	0	0	0	0	0	201	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(173)	(28,431)	4,050	0	0	0	0	0	0	0	0	(24,554)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(206)	(36,500)	4,050	0	0	0	0	0	0	0	0	(32,656)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cobden Rehabilitation and Nursing Center, LLC# 0051003

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

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	(5,052)	813	0	0	0	0	0	0	0	0	0	(4,239)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14)	152	0	0	0	0	0	0	0	0	0	138	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	2,764	0	0	0	0	0	0	0	0	0	2,764	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,066)	3,729	0	0	0	0	0	0	0	0	0	(1,337)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(5,272)	(32,771)	4,050	0	0	0	0	0	0	0	0	(33,993)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven Blisko	75	Anna Rehab & Nursing Center	Anna	Senior Healthcare	Skokie	Management Co
A&F General Partnership	25	Carbondale Rehab & Nursing	Carbondale			
Ted Lerman	5	Herrin Rehab & Nursing	Herrin			
		Marion Rehab & Nursing	Marion			
		Ridgway Rehab & Nursing	Ridgway			
		Alton Rehab & Nursing	Alton			
		Chester Rehab & Nursing	Chester			

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	10 Nursing Wages	\$ 26,017	Senior Healthcare Management		\$ 16,139	\$ (9,878)	1
2	V	21 Admin Wages	2,706	Senior Healthcare Management		57,134	54,428	2
3	V	5 Utilities		Senior Healthcare Management		1,800	1,800	3
4	V	19 Professional Services	107,500	Senior Healthcare Management		11,567	(95,933)	4
5	V	20 Dues, Fees, Subscriptions & Promotions		Senior Healthcare Management		89	89	5
6	V	21 Clerical & General Office Expense	3,836	Senior Healthcare Management		1,004	(2,832)	6
7	V	22 Employee Benefits & Payroll Taxes		Senior Healthcare Management		12,483	12,483	7
8	V	24 Travel and Seminar	51	Senior Healthcare Management		3,184	3,133	8
9	V	26 Insurance-Prop.Liab.Malpractice		Senior Healthcare Management		201	201	9
10	V	30 Depreciation		Senior Healthcare Management		813	813	10
11	V	32 Interest		Senior Healthcare Management		152	152	11
12	V	34 Rent-Facility & Grounds		Senior Healthcare Management		2,764	2,764	12
13	V	6 Repairs & Maintenance		Senior Healthcare Management		9	9	13
14	Total		\$ 140,110			\$ 107,339	\$ * (32,771)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Office Supplies	\$	Senior Healthcare Management		\$ 4,050	\$	4,050	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 4,050	\$ *	4,050	39

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Cobden Rehabilitation and Nursing Center, # 0051003 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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											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 Cobden Rehabilitation and Nursing Center, LLC # 0051003 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Cobden Rehabilitation and Nursing Center, L

0051003

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	Bank of Leumi USA		X	Working Capital		8/1/11	3,400,000	200,000	8/1/12	4.5000	5,974	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 3,400,000	\$ 200,000			\$ 5,974	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 3,400,000	\$ 200,000			\$ 5,974	15							

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

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.)

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 2010 report.		\$	(11,565)		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.)		\$	20,115		2
3. Under or (over) accrual (line 2 minus line 1).		\$	31,680		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(4,382)		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.		\$	27,298		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	_____	8	FOR BHF USE ONLY	
	2007	_____	9	13	FROM R. E. TAX STATEMENT FOR 2010 \$
	2008	_____	10		
	2009	27,489	11	14	PLUS APPEAL COST FROM LINE 5 \$
	2010	20,115	12		
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cobden Rehabilitation and Nursing Center, LLC COUNTY Union County

FACILITY IDPH LICENSE NUMBER 0051003

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-31-02-784-C</u>	<u>Nursing Facility</u>	\$ <u>20,114.50</u>	\$ <u>20,114.50</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>20,114.50</u></u>	\$ <u><u>20,114.50</u></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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 Cobden Rehabilitation and Nursing Center, LLC

0051003

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ 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: 12,225 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 815 4. Dates Incurred: Prior to 6/1/10

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				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Fire Panels		10/1/2011	7,852	50	39	50		50
10	Sprinklers		9/1/2011	154,499	1,321	39	1,321		1,321
11	Guard Rails		9/1/2011	18,200	156	39	156		156
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 7,824	\$	\$ 1,565	\$ 1,565	5	\$ 7,824	71
72	Current Year Purchases	6,449	6,449	645	(5,804)	5	6,449	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 14,273	\$ 6,449	\$ 2,210	\$ (4,239)		\$ 14,273	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	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)	\$ 194,824	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,976	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,737	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,239)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 15,800	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: Southern Illinois Healthcare Realty

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:	<u>1995</u>	<u>74</u>	<u>5/28/10</u>	\$ <u>415,539</u>	<u>20</u>	<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>74</u>		\$ <u>415,539</u>			7

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

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

N/A

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

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: \$ N/A Description: N/A

(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 6/1/10

Ending 5/31/30

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

Fiscal Year Ending Annual Rent

12. 12/31/12 \$ 438,536

13. 12/31/13 \$ 456,058

14. 12/31/14 \$ 476,458

* 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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		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**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$		\$ 66,915	\$		\$ 66,915	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			4,797			4,797	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			79,674			79,674	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				73,925		73,925	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Radiology & Lab</u>	39-2					4,710		4,710	12
13	Other (specify):									13
14	TOTAL			\$		\$ 151,386	\$ 78,635		\$ 230,021	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 **Cobden Rehabilitation and Nursing Center, LLC**

0051003

Report Period Beginning: **01/01/2011**

Ending: **12/31/2011**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2011** (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	\$ 81,033	\$ 81,033	1
2	Cash-Patient Deposits	(11,834)	(11,834)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	628,504	628,504	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 697,703	\$ 697,703	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	180,551	180,551	15
16	Equipment, at Historical Cost	14,273	14,273	16
17	Accumulated Depreciation (book methods)	(15,800)	(15,800)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,290)	(1,290)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Security Deposit</u>)	656	656	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 190,615	\$ 190,615	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 888,318	\$ 888,318	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 365,462	\$ 365,462	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,135	99,135	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Working Capital Note</u>	200,000	200,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 664,597	\$ 664,597	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 664,597	\$ 664,597	46
47	TOTAL EQUITY(page 18, line 24)	\$ 223,721	\$ 223,721	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 888,318	\$ 888,318	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,157)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,157)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	277,878	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	(50,000)	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)	\$ 227,878	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)	\$ 223,721	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cobden Rehabilitation and Nursing Center, LLC # 0051003 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	\$ 2,627,839	1
2	Discounts and Allowances for all Levels	83,200	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,711,039	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,742	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 34,742	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	16,965	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,059	19
20	Radiology and X-Ray	22	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,046	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,763,841	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	503,466	31
32	Health Care	963,885	32
33	General Administration	441,745	33
B. Capital Expense			
34	Ownership	457,602	34
C. Ancillary Expense			
35	Special Cost Centers	78,750	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,485,963	40
41	Income before Income Taxes (line 30 minus line 40)**	277,878	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 277,878	43

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

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

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

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

Facility Name & ID Number **Cobden Rehabilitation and Nursing Center, LLC**

0051003

Report Period Beginning: **01/01/2011**

Ending:

12/31/2011

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	2,109	2,228	\$ 48,449	\$ 21.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,665	3,868	75,460	19.51	3
4	Licensed Practical Nurses	7,042	7,534	108,814	14.44	4
5	CNAs & Orderlies	36,873	39,319	342,343	8.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,770	2,924	26,407	9.03	9
10	Activity Assistants					10
11	Social Service Workers	3,733	4,005	35,707	8.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,416	12,949	112,097	8.66	15
16	Dishwashers					16
17	Maintenance Workers	1,674	1,718	16,406	9.55	17
18	Housekeepers	10,990	11,511	95,012	8.25	18
19	Laundry	4,957	5,182	43,250	8.35	19
20	Administrator	2,020	2,194	39,520	18.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,610	1,918	26,855	14.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS	3,953	4,182	64,134	15.34	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	93,812	99,532	\$ 1,034,454 *	\$ 10.39	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	132	\$ 4,607	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	61	3,052	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	88	3,091	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	\$ 10,750		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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Gayle Yates	ADMIN	0	\$ 39,520	Workers' Compensation Insurance	\$ 45,641	IDPH License Fee	\$ 3,064	
				Unemployment Compensation Insurance	12,175	Advertising: Employee Recruitment		
				FICA Taxes	84,312	Health Care Worker Background Check		
				Employee Health Insurance	11,717	(Indicate # of checks performed _____)		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Senior Healthcare License/Fees/Dues	89	
				Employee Expense	11,925	CLIA Lab Program Certification	150	
						Secretary of State License	250	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 39,520					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,553	
(Attach a copy of any management service agreement)								
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
Senior Healthcare	Professional		\$ 107,500			\$	Out-of-State Travel	\$
Accrued Expenses	Accounting		2,000					
Bradley Associates	Accounting		7,947					
Johnson Goldberg	Accounting		2,500				In-State Travel	
Neil, Gerber, Eisenberg	Legal		13,712				Mileage	879
							Auto Allowance	3,945
							Senior Healthcare Travel Expense	3,097
							Seminar Expense	
							Education	206
							Meals	36
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 133,659				TOTAL	\$ 8,163

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cobden Rehabilitation and Nursing Center, LLC# 0051003Report Period Beginning: 01/01/2011 Ending: 12/31/2011**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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,941 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ 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. \$ 40,515
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? N/A
- (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? N/A 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. \$ None 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
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? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT