FOR BHF USE

LL1

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.

I. IDPH License ID Number: 0051367

Facility Name: Nathan Health Care Center LLC

Address: 5050 Summit Avenue (Number) East St Louis (City) 62203 (Zip Code)

County: St Clair

Telephone Number: 618-874-3597 **Fax #** 618-874-0240

HFS ID Number:

Date of Initial License for Current Owners: 04/01/2011

Type of Ownership:

	VOLUNTARY,NON-PROFIT		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: Ashwin Dundoo **Telephone Number:** 314-543-3803
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/2011 to 12/31/2011 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) (Date)
(Print Name and Title) Marc Feldman, CPA
(Firm Name & Address) Healthcare Financial Solutions, LLC, 9141 Reisterstown Road #9, Owings Mills, MD 21117
(Telephone) (410) 654-4036 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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 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	150	Skilled (SNF)	150	42,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	42,750	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	16,463	715	3,893	21,071	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,463	715	3,893	21,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.29%

D. How many bed-hold days during this year were paid by the Department?
79 (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 [X] NO [ ]

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 04/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 1,182

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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	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	133,415	15,376	14,532	163,323		163,323		163,323			1
2	Food Purchase		112,534		112,534		112,534		112,534			2
3	Housekeeping	85,623	9,643		95,266		95,266		95,266			3
4	Laundry	44,189	12,344	2,210	58,743		58,743		58,743			4
5	Heat and Other Utilities			83,244	83,244		83,244	(801)	82,443			5
6	Maintenance	30,841	20,949	56,028	107,818		107,818		107,818			6
7	Other (specify):*											7
8	TOTAL General Services	294,068	170,846	156,014	620,928		620,928	(801)	620,127			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	939,429	77,850	6,160	1,023,439		1,023,439		1,023,439			10
10a	Therapy			306,680	306,680		306,680		306,680			10a
11	Activities	33,616	7,152	2,868	43,636		43,636		43,636			11
12	Social Services	37,940			37,940		37,940		37,940			12
13	CNA Training											13
14	Program Transportation		3,768		3,768		3,768		3,768			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,010,985	88,770	324,108	1,423,863		1,423,863		1,423,863			16
	C. General Administration											
17	Administrative	102,461	19,989	399,128	521,578		521,578	(140,320)	381,258			17
18	Directors Fees											18
19	Professional Services			11,320	11,320		11,320		11,320			19
20	Dues, Fees, Subscriptions & Promotions			1,324	1,324		1,324		1,324			20
21	Clerical & General Office Expenses	43,254		2,633	45,887		45,887		45,887			21
22	Employee Benefits & Payroll Taxes			263,591	263,591		263,591		263,591			22
23	Inservice Training & Education			13,383	13,383		13,383		13,383			23
24	Travel and Seminar			70,374	70,374		70,374		70,374			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,562	18,562		18,562		18,562			26
27	Other (specify):*											27
28	TOTAL General Administration	145,715	19,989	780,315	946,019		946,019	(140,320)	805,699			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,450,768	279,605	1,260,437	2,990,810		2,990,810	(141,121)	2,849,689			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Nathan Health Care Center LLC #0051367 Report Period Beginning: 04/01/2011 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			800	800		800		800			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,706	7,706		7,706	(18)	7,688			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			443,709	443,709		443,709		443,709			34
35	Rent-Equipment & Vehicles			21,002	21,002		21,002		21,002			35
36	Other (specify):*											36
37	**TOTAL Ownership**			473,217	473,217		473,217	(18)	473,199			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,684	5,919	92,603		92,603		92,603			39
40	Barber and Beauty Shops		43	220	263		263		263			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,425	61,425		61,425		61,425			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		86,727	67,564	154,291		154,291		154,291			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,450,768	366,332	1,801,218	3,618,318		3,618,318	(141,139)	3,477,179			45

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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	(801)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2)	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	(16)	32		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	(1,040)	17		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	(112,740)	17		24
25	Fund Raising, Advertising and Promotional	(26,540)	17		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 Promotion				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (141,139)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (141,139)		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	Chargeable Supplies		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Nathan Health Care Center LLC

ID# 0051367

Report Period Beginning: 04/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 **Report Period Beginning:** 04/01/2011 **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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(801)	0	0	0	0	0	0	0	0	0	0	(801)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(801)	0	0	0	0	0	0	0	0	0	0	(801)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(140,320)	0	0	0	0	0	0	0	0	0	0	(140,320)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(140,320)	0	0	0	0	0	0	0	0	0	0	(140,320)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(141,121)	0	0	0	0	0	0	0	0	0	0	(141,121)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 **Report Period Beginning:** 04/01/2011 **Ending:** 12/31/2011

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18)	0	0	0	0	0	0	0	0	0	0	(18)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(18)	0	0	0	0	0	0	0	0	0	0	(18)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(141,139)	0	0	0	0	0	0	0	0	0	0	(141,139)	45

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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
See Supplemental Schedule		See Supplemental Schedule				

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		Management Fees	$ 219,897	Reliant Care Management	100.00%	$ 219,897	$	1
2	V								2
3	V								3
4	V								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			$ 219,897			$ 219,897	$ *	14

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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	Reliant Care Group	100	Bernard Care Center, LLC	Missouri	Bernard Associates	Missouri	Lessor	1
2			Chariton Park Health Care Center, LLC	Missouri	Salisbury Associates	Missouri	Lessor	2
3			Four Seasons Living Center, LLC	Missouri	Sedalia Associates	Missouri	Lessor	3
4			Heritage Associates of Berkeley, LLC	Missouri	Heritage Park	Missouri	Lessor	4
5			Levering Regional HCC, LLC	Missouri	Levering Associates	Missouri	Lessor	5
6			North Village Park, LLC	Missouri	M-S Associates	Missouri	Lessor	6
7			Bridgewood Healthcare Center, LLC	Missouri	Bridgewood Associates	Missouri	Lessor	7
8			Crestwood Healthcare Center, LLC	Missouri	Crestwood Associates	Missouri	Lessor	8
9			MMA Healthcare of St. Elizabeth, Inc	Missouri	BKY Properties of Eliz	Missouri	Lessor	9
10			MMA Healthcare of Viburnum, Inc	Missouri	BYY Properties of Vib	Missouri	Lessor	10
11			MMA Healthcare Center, Inc	Missouri	BKY Properties	Missouri	Lessor	11
12			BKY Healthcare of Milan, Inc	Missouri	BKY Properties of Mil	Missouri	Lessor	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 Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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 [X] NO [ ]

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

Name of Related Organization: Reliant Care Management Company
Street Address: 9200 Watson Road, Ste 201
City / State / Zip Code: St. Louis, MO 63126
Phone Number: (314) 543-3800
Fax Number: (314) 543-3880

	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	17	Management Fees	Operating Costs	82,913,745	26	$ 3,412,300	$	5,343,166	$ 219,897	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					$ 3,412,300	$		$ 219,897	25

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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	
	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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank of Cairo		X	Fund operating needs	No	4/1/2011	502,150	502,150	None	0.0500	7,690	6
7												7
8												8
9	TOTAL Facility Related						$ 502,150	$ 502,150			$ 7,690	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 502,150	$ 502,150			$ 7,690	15

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

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

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

Facility Name & ID Number Nathan Health Care Center LLC **#** 0051367 **Report Period Beginning:** 04/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	197,469	8
2007	142,987	9
2008	114,901	10
2009	99,870	11
2010	70,811	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nathan Health Care Center LLC COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0051367

CONTACT PERSON REGARDING THIS REPORT Ashwin Dundoo

TELEPHONE 314-543-3803 FAX #: ( )

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-21.0-209-023	Johnson Place	$ 70,811.11	$ 70,811.11
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,811.11	$ 70,811.11

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 Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2001	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	150		2001		$ 4,801,297	$	Various	$ 99,022	$ 99,022	$ 1,331,291	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	30,239		20	1,134	1,134	25,949	9
10	Various			1995	25,180		20	944	944	21,231	10
11	Various			1996	5,688		20	213	213	4,452	11
12	Various			1997	4,115		20	154	154	3,020	12
13	Various			1998	4,092		20	153	153	3,036	13
14	Various			1999	27,640		20	1,037	1,037	17,497	14
15	Concrete Work			2000	3,181		20	119	119	1,829	15
16	Concrete Work			2000	5,030		20	189	189	2,893	16
17	Concrete Work			2000	5,195		20	195	195	2,988	17
18	Exhaust Fan			2000	3,820		20	143	143	2,451	18
19	Water Heater			2000	5,300		20	199	199	3,357	19
20	Carpeting			2000	5,400		20	203	203	3,330	20
21	Mechanical Room Valve			2000	1,315		20	49	49	725	21
22	Check Valve			2000	877		20	33	33	483	22
23	Plumbing			2000	1,024		20	38	38	562	23
24	100 Gallon Water Heater			2001	4,642		20	174	174	3,624	24
25	Steamer			2001	2,545		20	95	95	1,985	25
26	Concentrator			2001	2,703		7	290	290	3,089	26
27	Air Conditioner			2001	1,895		20	71	71	1,479	27
28	Fire Protection			2001	6,752		20	253	253	5,272	28
29	Air Conditioner			2001	8,313		20	312	312	6,490	29
30	Sprinkler Heads			2001	3,273		20	123	123	2,556	30
31	Blinds			2001	1,212		20	45	45	948	31
32	Sprinkler System Repair			2001	1,827		20	69	69	943	32
33	Heating System Repair			2001	1,269		20	48	48	639	33
34	Dining Room Wall			2002	11,663		10	875	875	11,274	34
35	Dining Room Wall			2002	8,020		10	602	602	7,753	35
36				2002	1,659		7	178	178	1,896	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioners	2002	$ 2,185	$	20	$	$	$ 2,185	37
38	Front Door	2003	9,860		20	370	370	4,437	38
39	Roof	2003	72,800		20	2,730	2,730	32,153	39
40	Gutters and Soffits	2003	24,221		20	908	908	10,495	40
41	Nursing Station	2003	2,901		20	109	109	1,269	41
42	Nursing Station	2003	13,285		20	498	498	5,812	42
43	Nursing Station	2003	12,188		20	457	457	5,128	43
44	Fire Sprinkler System	2003	2,075		20	78	78	892	44
45	Fire Suppression System	2003	2,030		20	76	76	864	45
46	100 Gallon Water Heater	2003	3,085		20	116	116	1,387	46
47	Resident Room Caseword/Counters	2003	7,259		20	272	272	3,146	47
48	Pipe/Dry System	2004	2,472		20	93	93	928	48
49	Air Compressor	2004	2,766		20	104	104	1,037	49
50	Condensing Unit/Evaporator	2004	2,230		20	84	84	837	50
51	Concrete Removal/New Pipe	2004	6,111		20	229	229	2,293	51
52	Air Conditioners - Laundry	2004	3,329		20	125	125	1,247	52
53	Sprinkler System	2004	2,056		20	77	77	771	53
54	Duct Heater	2005	1,381		20	52	52	449	54
55	Freezer Door	2005	2,100		20	79	79	682	55
56	Wallpaper	2005	14,510		20	544	544	4,717	56
57	Water Heaters	2005	5,724		20	215	215	1,860	57
58	Security System	2005	25,534		20	958	958	8,299	58
59	Compressor	2005	1,090		20	41	41	354	59
60	Water Heaters	2005	1,490		20	56	56	485	60
61	Painting & Wallcovering	2005	38,792		20	1,455	1,455	12,608	61
62	Carpet	2005	3,164		20	119	119	1,028	62
63	Vinyl Floor	2005	6,327		20	237	237	2,056	63
64	Doors	2005	1,925		20	72	72	625	64
65	Asphalt for Parking Lot	2005	8,500		20	319	319	2,763	65
66	Custom Built Duct Heater	2005	1,704		20	64	64	553	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,268,260	$		$ 117,493	$ 117,493	$ 1,584,399	70

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,268,260	$		$ 117,493	$ 117,493	$ 1,584,399	1
2	Kitchen Floor	2006	10,000		20	375	375	3,020	2
3	Air Conditioning Unit	2006	2,146		20	80	80	590	3
4	Air Conditioning Unit	2006	2,576		20	97	97	709	4
5	2 Ton Air Conditioning Unit	2006	1,208		20	45	45	331	5
6	Sprinkler System - Replace Pipes	2006	8,357		20	313	313	2,299	6
7	Remodel Shower Hall -500	2007	21,570		20	809	809	4,854	7
8	Remodel Shower Hall -400	2007	21,570		20	809	809	4,854	8
9	Remodel Shower Hall -200	2007	21,570		20	809	809	4,854	9
10	Handrail	2007	3,425		20	128	128	770	10
11	Freezer Compressor	2007	2,202		20	83	83	495	11
12	5 Ton Air Handler	2007	2,795		20	105	105	629	12
13	2 Ton Air Handler & 3 Ton Condensing Unit	2007	5,241		20	197	197	1,179	13
14	Asphalt Parking Lot	2008	28,482		20	1,068	1,068	4,984	14
15	Asphalt Path	2008	9,820		20	368	368	1,719	15
16	Sprinkler System Renovation	2008	16,034		20	601	601	2,807	16
17	Roof Repair - Burst Pipe in Kitchen	2009	10,868		20	408	408	1,358	17
18	Sprinkler System	2009	2,637		20	99	99	330	18
19	Pond with 2 Streams, Waterfalls & Cross Bridges	2010	38,840		20	1,457	1,457	2,913	19
20	Gazebo	2010	8,034		20	301	301	603	20
21	Fire Sprinkler Head Replacement	2011	26,866	299	20	299		299	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	TOTAL (lines 1 thru 33)		$ 5,512,501	$ 299		$ 125,943	$ 125,644	$ 1,623,994	34

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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	$ 53,335	$	$ 3,407	$ 3,407		$ 32,254	71
72	Current Year Purchases	7,515	501	501			501	72
73	Fully Depreciated Assets	933,526						73
74								74
75	TOTALS	$ 994,376	$ 501	$ 3,908	$ 3,407		$ 32,755	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)	$ 6,906,877	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 800	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 129,851	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 129,052	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,656,749	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Virgil Calvert Property LLC
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 [X] 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:		150	4/1/2011	$ 443,709	5		3
4	Additions							4
5								5
6								6
7	TOTAL		150		$ 443,709 **			7

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

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 4/1/2011
Ending 3/31/2016

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2012	$ 443,709
13.	12/31/2013	$ 443,709
14.	12/31/2014	$ 443,709

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ Description: (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

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

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	hrs	$	1,910	$ 131,806	$	1,910	$ 131,806	1
2	Licensed Speech and Language Development Therapist	10A	hrs		747	51,514		747	51,514	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	hrs		1,701	117,360		1,701	117,360	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				61,289		61,289	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	4,358	$ 300,680	$ 61,289	4,358	$ 361,969	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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	$ (40,509)	$	1
2	Cash-Patient Deposits	51,838		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 117,198)	1,263,921		3
4	Supply Inventory (priced at cost)	4,420		4
5	Short-Term Investments			5
6	Prepaid Insurance	688		6
7	Other Prepaid Expenses	4,395		7
8	Accounts Receivable (owners or related parties)	16,262		8
9	Other(specify): Deposits	2,051		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,303,066	$	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	26,866		15
16	Equipment, at Historical Cost	7,515		16
17	Accumulated Depreciation (book methods)	(800)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 33,581	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,336,647	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 169,902	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,838		28
29	Short-Term Notes Payable	502,150		29
30	Accrued Salaries Payable	117,927		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,378		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	Accrued Fees, Withholdings	2,827		36
37	Due to Home Office	957,067		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,814,090	$	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)**	$ 1,814,090	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (477,442)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,336,647	$	48

*(See instructions.)

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 **Report Period Beginning:** 04/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(477,443)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding Error**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (477,442)	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)**	$ (477,442)	24 *

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,494,267	1
2	Discounts and Allowances for all Levels	64,130	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,558,397	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	513,430	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 513,430	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,682	19
20	Radiology and X-Ray	135	20
21	Other Medical Services	59,979	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 61,796	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	7,250	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,250	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,140,875	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	620,928	31
32	Health Care	1,423,863	32
33	General Administration	946,019	33
	B. Capital Expense		
34	Ownership	473,217	34
	C. Ancillary Expense		
35	Special Cost Centers	154,291	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,618,318	40
41	**Income before Income Taxes (line 30 minus line 40)****	(477,443)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (477,443)	43

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

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

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

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

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,572	1,572	$ 64,246	$ 40.87	1
2	Assistant Director of Nursing	418	418	12,094	28.93	2
3	Registered Nurses	1,884	1,884	50,224	26.66	3
4	Licensed Practical Nurses	16,950	16,950	342,287	20.19	4
5	CNAs & Orderlies	33,878	33,878	348,169	10.28	5
6	CNA Trainees	453	453	5,564	12.28	6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides	781	781	9,287	11.89	8
9	Activity Director		0			9
10	Activity Assistants	3,044	3,044	33,371	10.96	10
11	Social Service Workers	2,742	2,742	41,976	15.31	11
12	Dietician		0			12
13	Food Service Supervisor		0			13
14	Head Cook		0			14
15	Cook Helpers/Assistants	13,328	13,328	128,000	9.60	15
16	Dishwashers		0			16
17	Maintenance Workers	1,942	1,942	29,947	15.42	17
18	Housekeepers	8,926	8,926	85,642	9.59	18
19	Laundry	4,608	4,608	44,189	9.59	19
20	Administrator	1,817	1,817	75,726	41.68	20
21	Assistant Administrator		0			21
22	Other Administrative		0			22
23	Office Manager	832	832	12,769	15.35	23
24	Clerical	574	574	6,736	11.74	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator	1,044	1,044	26,134	25.03	29
30	Habilitation Aides (DD Homes)		0			30
31	Medical Records	1,677	1,677	20,057	11.96	31
32	Other Health C: Schedule, MDS, C	2,259	2,259	55,183	24.43	32
33	Other(specify) Marketing	1,200	1,200	20,700	17.25	33
34	TOTAL (lines 1 - 33)	99,929	99,929	$ 1,412,301 *	$ 14.13	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		$ 10,239	1	35
36	Medical Director		8,400	9	36
37	Medical Records Consultant				37
38	Nurse Consultant		5,950	10	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,868	11	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,457		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Monte Hanson	Administrator	0	$ 12,250
Debra Ford	Administrator	0	24,682
Latrese Washington	Administrator	0	38,795
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,727

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
BOBROFF, HESSE, MARTONE &	Legal	$ 5,568
Rubin Brown	Audit	2,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,068

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,412
Unemployment Compensation Insurance	
FICA Taxes	174,016
Employee Health Insurance	30,163
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 263,591

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

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 900
Advertising: Employee Recruitment	5,910
Health Care Worker Background Check	450
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,260

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 70,189
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 70,189

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 Ending: 12/31/2011

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	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Nathan Health Care Center LLC # 0051367 Report Period Beginning: 04/01/2011 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. $ **13,969** 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.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **61,425**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5.4**
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? **N/A**
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. $

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.