		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.

I. IDPH License ID Number: 0047126

Facility Name: St. Anthony's Nursing & Rehab Center

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

County: Rock Island

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 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) SEE ACCOUNTANTS' PREPARATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,390	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	651	470	3,884	5,005	8
9	SNF/PED					9
10	ICF	28,858	5,487		34,345	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,509	5,957	3,884	39,350	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.93%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 44 and days of care provided 3,884

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 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	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	230,065	18,078	6,882	255,025		255,025		255,025			1
2	Food Purchase		227,841		227,841		227,841		227,841			2
3	Housekeeping	145,652	37,823		183,475		183,475		183,475			3
4	Laundry	51,606	41,189		92,795		92,795		92,795			4
5	Heat and Other Utilities			267,559	267,559		267,559	(44)	267,515			5
6	Maintenance	148,205		122,920	271,125		271,125	15,716	286,841			6
7	Other (specify):*											7
8	**TOTAL General Services**	575,528	324,931	397,361	1,297,820		1,297,820	15,672	1,313,492			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,879,295	124,709	13,261	2,017,265		2,017,265	228,447	2,245,712			10
10a	Therapy		386	475,439	475,825		475,825		475,825			10a
11	Activities	48,510	16,601	1,302	66,413		66,413		66,413			11
12	Social Services	27,161		2,914	30,075		30,075		30,075			12
13	CNA Training											13
14	Program Transportation			1,359	1,359		1,359		1,359			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,954,966	141,696	515,875	2,612,537		2,612,537	228,447	2,840,984			16
	C. General Administration											
17	Administrative	116,124		307,835	423,959		423,959	(307,183)	116,776			17
18	Directors Fees											18
19	Professional Services			75,657	75,657		75,657	44,453	120,110			19
20	Dues, Fees, Subscriptions & Promotions			24,659	24,659		24,659	1,939	26,598			20
21	Clerical & General Office Expenses	81,997	3,842	92,347	178,186		178,186	26,697	204,883			21
22	Employee Benefits & Payroll Taxes			320,967	320,967		320,967		320,967			22
23	Inservice Training & Education							501	501			23
24	Travel and Seminar			523	523		523	22,676	23,199			24
25	Other Admin. Staff Transportation			17,005	17,005		17,005		17,005			25
26	Insurance-Prop.Liab.Malpractice			70,106	70,106		70,106	138,634	208,740			26
27	Other (specify):*							31,705	31,705			27
28	**TOTAL General Administration**	198,121	3,842	909,099	1,111,062		1,111,062	(40,578)	1,070,484			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,728,615	470,469	1,822,335	5,021,419		5,021,419	203,541	5,224,960			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 St. Anthony's Nursing & Rehab Center #0047126 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,044	30,044		30,044	76,108	106,152			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,485	63,485		63,485	743,506	806,991			32
33	Real Estate Taxes			81,763	81,763		81,763		81,763			33
34	Rent-Facility & Grounds			942,420	942,420		942,420	(933,707)	8,713			34
35	Rent-Equipment & Vehicles			23,879	23,879		23,879	3,692	27,571			35
36	Other (specify):*											36
37	TOTAL Ownership			1,141,591	1,141,591		1,141,591	(110,401)	1,031,190			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		342,625		342,625		342,625		342,625			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,175	71,175		71,175		71,175			42
43	Other (specify):* Non-Allow Costs	74,826		51,616	126,442		126,442	(126,442)				43
44	TOTAL Special Cost Centers	74,826	342,625	122,791	540,242		540,242	(126,442)	413,800			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,803,441	813,094	3,086,717	6,703,252		6,703,252	(33,302)	6,669,950			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 St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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	(10,462)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(38,065)	30		9
10	Interest and Other Investment Income	(24,452)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(31,096)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(99,445)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (203,520)		$	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)	170,218		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 170,218		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (33,302)		37

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

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

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

St. Anthony's Nursing & Rehab Center

ID# 0047126

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (74,826)	43	1
2	Labs - Part A	(8,539)	43	2
3	Radiology & EKG - Medicare	(1,281)	43	3
4	Penalties	(373)	43	4
5				5
6	Other Services - Medicare	135	43	6
7	Offset Goodwill Amort.	(6,165)	31	7
8	Misc Income Facility	(379)	21	8
9	Repair & Maintenance	15,716	6	9
10	Disallow interest in excess of prime paid to			10
11	related party.	(23,733)	32	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**	(99,445)		49

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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
Suzanne Koenig	90%	Lena Living Center	Lena	SAK Management Ser	Northfield	Mgmt. Co.
Gary Weintraub	10%			St. Anthony's Property	Rock Island	Real Estate Entity
				Lena Propert Partners	Lena	Real Estate Entity

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Clerical - Other	$	St. Anthony's Property Partners	100.00%	$ 500	$ 500	1
2	V	30	Depreciation		St. Anthony's Property Partners	100.00%	114,000	114,000	2
3	V	31	Amortization		St. Anthony's Property Partners	100.00%	6,165	6,165	3
4	V	34	Rent- Facility & Grounds	942,420	St. Anthony's Property Partners	100.00%		(942,420)	4
5	V	32	Loan Interest		St. Anthony's Property Partners	100.00%	788,891	788,891	5
6	V	26	Mortgage Insurance		St. Anthony's Property Partners	100.00%	136,292	136,292	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 942,420			$ 1,045,848	$ * 103,428	14

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$ 44	SAK Management Services, LLC	90.00%	$	$ (44)	15
16	V	10	Nursing - Salaries		SAK Management Services, LLC	90.00%	228,447	228,447	16
17	V	17	Administrative - Salaries	307,835	SAK Management Services, LLC	90.00%	652	(307,183)	17
18	V	19	Professional Fees		SAK Management Services, LLC	90.00%	44,453	44,453	18
19	V	20	Dues,Fees & Subs		SAK Management Services, LLC	90.00%	1,939	1,939	19
20	V	21	Clerical		SAK Management Services, LLC	90.00%	26,576	26,576	20
21	V	23	Training/Education		SAK Management Services, LLC	90.00%	501	501	21
22	V	24	Travel/Seminar		SAK Management Services, LLC	90.00%	22,676	22,676	22
23	V	25	Other Admin. Transp		SAK Management Services, LLC	90.00%			23
24	V	26	Insurance - Prop/Liability		SAK Management Services, LLC	90.00%	2,342	2,342	24
25	V	27	EE Benefits		SAK Management Services, LLC	90.00%	31,705	31,705	25
26	V	30	Depreciation Expense		SAK Management Services, LLC	90.00%	173	173	26
27	V	32	Interest		SAK Management Services, LLC	90.00%	2,800	2,800	27
28	V	34	Rent - Facility & Grounds		SAK Management Services, LLC	90.00%	8,713	8,713	28
29	V	35	Rent - Eqpt. & Vehicles		SAK Management Services, LLC	90.00%	3,692	3,692	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			$ 307,879			$ 374,669	$ * 66,790	39

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 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	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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 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 [X] NO [ ]

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

Name of Related Organization: SAK Management Services, LLC
Street Address: 1 Northfield Plaza, Suite 480
City / State / Zip Code: Northfield, IL 60093
Phone Number: (847) 446-8400
Fax Number: (847) 446-8432

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	SAK Management Fees	1,548,791	14	$ (221)	$	307,835	$ (44)	1
2	10	Nursing - Salaries	SAK Management Fees	1,548,791	14	1,149,374	1,149,374	307,835	228,447	2
3	17	Administrative - Salaries	SAK Management Fees	1,548,791	14	3,281		307,835	652	3
4	19	Professional Fees	SAK Management Fees	1,548,791	14	223,652		307,835	44,453	4
5	20	Dues,Fees & Subs	SAK Management Fees	1,548,791	14	9,758		307,835	1,939	5
6	21	Clerical	SAK Management Fees	1,548,791	14	133,712		307,835	26,576	6
7	23	Training/Education	SAK Management Fees	1,548,791	14	2,519		307,835	501	7
8	24	Travel/Seminar	SAK Management Fees	1,548,791	14	114,086		307,835	22,676	8
9										9
10	26	Insurance - Prop/Liability	SAK Management Fees	1,548,791	14	11,781		307,835	2,342	10
11	27	EE Benefits	SAK Management Fees	1,548,791	14	159,513		307,835	31,705	11
12	30	Depreciation Expense	SAK Management Fees	1,548,791	14	869		307,835	173	12
13	34	Rent - Facility & Grounds	SAK Management Fees	1,548,791	14	43,837		307,835	8,713	13
14	35	Rent - Eqpt. & Vehicles	SAK Management Fees	1,548,791	14	18,573		307,835	3,692	14
15										15
16	32	Interest	SAK Management Fees	1,548,791	14	14,088		307,835	2,800	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,884,822	$ 1,149,374		$ 374,625	25

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD			Mortgage		12/17/2009	$ 11,995,400	$ 11,886,647	12/18/2047	0.0675	$ 788,891	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Cole Taylor Bank		X	LOC				622,993	12/31/2011	0.0600	33,187	6
7	SAK Management	X		Working Capital		12/17/2009	186,449	186,449	12/31/2011	0.1500	30,298	7
8	Suzanna A Koenig	X		Working Capital			169,386	274,386				8
9	TOTAL Facility Related						$ 12,351,235	$ 12,970,475			$ 852,376	9
	B. Non-Facility Related*											
10												10
11								Disallow excess related party interest			(23,733)	11
12								Interest Income Offset			(24,452)	12
13								Allocation from Mgmt Co.			2,800	13
14	TOTAL Non-Facility Related						$	$			$ (45,385)	14
15	TOTALS (line 9+line14)						$ 12,351,235	$ 12,970,475			$ 806,991	15

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

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

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 **Report Period Beginning:** 01/01/2011 **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.**		$ 27,726	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.)	2010	$ 83,429	2
3. Under or (over) accrual (line 2 minus line 1).		$ 55,703	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 90,456	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
	Unreconciled Difference	(64,396)	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 81,763	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	69,864	8
	2007	71,793	9
	2008	76,109	10
	2009	75,291	11
	2010	83,429	12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 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 St. Anthony's Nursing & Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Suzanne Koenig

TELEPHONE (847) 446-8400 FAX #: (847) 446 -8432

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.	09-231-19-00	Long Term Care Property	$ 1,466.00	$ 1,466.00
2.	09-430-04-00	Long Term Care Property	$ 74,625.00	$ 74,625.00
3.	09-430-05-00	Long Term Care Property	$ 7,338.00	$ 7,338.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,429.00	$ 83,429.00

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 St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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	140		2005	1974	$ 2,050,000	$	35	$ 58,571	$ 58,571	$ 409,997	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security & Monitoring System			2005	3,522		20	176	176	1,384	9
10	Boiler			2005	24,087		10	2,409	2,409	15,659	10
11	Boiler repairs			2008	18,233	3,189	7	2,604	(585)	9,114	11
12	Heater System Reapair			2009	4,635	1,135	7	662	(473)	1,986	12
13	Boiler Repairs			2010	22,384	3,199	7	3,199		4,798	13
14	New Water Heater			2011	7,920		20	198	198	198	14
15	drain repairs			2011	3,108	622	7	222	(400)	222	15
16	Oxygen fill system-cylinders & cart			2011	2,669	534	7	191	(343)	191	16
17	broken steam line repairs			2011	4,195	839	7	300	(539)	300	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,140,752	$ 9,518		$ 68,531	$ 59,013	$ 443,848	70

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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	$ 330,868	$ 14,919	$ 34,465	$ 19,546	10	$ 228,417	71
72	Current Year Purchases	16,734	3,346	1,581	(1,765)		1,581	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			173	173			74
75	TOTALS	$ 347,602	$ 18,265	$ 36,219	$ 17,954		$ 229,998	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	Facility	Ford Winstar	2005	$ 1,506	$ 135	$ 302	$ 167	5	$ 1,812	76
77	Facility	Snow Plow Truck	2010	5,500	2,126	1,100	(1,026)	5	1,650	77
78										78
79										79
80	TOTALS			$ 7,006	$ 2,261	$ 1,402	$ (859)		$ 3,462	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	2,645,360	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	30,044	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	106,152	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	76,108	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	677,308	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	RE-Contruction Reserve-CT	$ 668	92
93	RE-Construction-in-Progress	6,383,875	93
94			94
95		$ 6,384,543	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 St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6	Allocated from Management Company				8,713			6
7	TOTAL				$ 8,713 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 27,571 Description: See schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$ N/A	$	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.

St. Anthony's Nursing & Rehab Center
FYE: 12/31/2011
Schedule 14A

Description	***Amount***
Stand Lift with Scale	626
SANRC 9/23	695
Copier Rental	7,489
Postage Meter Rental	86
Concentrators	3,497
Nursing Supplies Rental	9,788
Weight scale	1,698
Home Office Allcoation	3,692
Total Rental Exp.	**27,571**

See Accountants' Preparation Report

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,578	$ 177,862	$ 386	2,578	$ 178,248	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		838	57,853		838	57,853	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,476	239,724		3,476	239,724	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				284,892		284,892	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): oxygen	39(2)					57,733		57,733	12
13	Other (specify):									13
14	TOTAL			$	6,892	$ 475,439	$ 343,011	6,892	$ 818,450	14

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

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 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	$ 3,234	$ 3,989	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (652,908))	1,545,685	1,545,685	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	60,609	60,609	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	65,153	1,286,146	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,674,681	$ 2,896,429	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,050,000	14
15	Leasehold Improvements, at Historical Cost		90,752	15
16	Equipment, at Historical Cost	163,348	354,608	16
17	Accumulated Depreciation (book methods)	(89,390)	(677,308)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		92,500	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(50,600)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Sch 17A		6,384,543	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 73,958	$ 8,394,495	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,748,639	$ 11,290,924	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,919,995	$ 2,052,352	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	158,961	158,961	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,281	20,281	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90,456	32
33	Accrued Interest Payable		63,956	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to/From St. Anthony's Prop, LLC	2,401,072		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,500,309	$ 2,386,006	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,083,828	1,083,828	39
40	Mortgage Payable		11,886,647	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)**	$ 1,083,828	$ 12,970,475	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,584,137	$ 15,356,481	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,835,498)	$ (4,065,557)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,748,639	$ 11,290,924	48

***(See instructions.)**

St. Anthony's Nursing & Rehab Center
Provider #: 0047126
01/01/11 - 12/31/11

Schedule 17A

XV. Balance Sheet

Line 9 - Other Current Assets (specify)	Operating	After Consolidation
Construction Escrow	-	952,238
Loan Issuance Costs	-	174,787
Due from Medicare	118,910.00	118,910
Replacement Reserve Escrow	-	93,968
Security Deposits	65,153	65,153
Total Line 9 - Other Current Assets	184,063	1,405,056

Line 22 - Other Long Term Assets (specify)		
RE-Construction Reserve-C.T.	-	668
RE-Construction in Process	-	6,383,875
Total Line 22 - Other Long Term Assets	-	6,384,543

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,278,591)	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	(13,337)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,291,928)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(543,570)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (543,570)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,835,498)	24	*

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,741,113	1
2	Discounts and Allowances for all Levels	92,758	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,833,871	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,024,393	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,024,393	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	298,754	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 298,754	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,612	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,612	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	52	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 52	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,159,682	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,297,820	31
32	Health Care	2,612,537	32
33	General Administration	1,111,062	33
	B. Capital Expense		
34	Ownership	1,141,591	34
	C. Ancillary Expense		
35	Special Cost Centers	469,067	35
36	Provider Participation Fee	71,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,703,252	40
41	**Income before Income Taxes (line 30 minus line 40)****	(543,570)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (543,570)	43

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

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

*** **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 St. Anthony's Nursing & Rehab Center # 0047126 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,024	2,080	$ 63,426	$ 30.49	1
2	Assistant Director of Nursing	1,888	2,080	48,637	23.38	2
3	Registered Nurses	9,692	10,540	242,852	23.04	3
4	Licensed Practical Nurses	24,307	26,187	469,825	17.94	4
5	CNAs & Orderlies	83,598	89,748	972,038	10.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,494	4,803	48,510	10.10	9
10	Activity Assistants					10
11	Social Service Workers	1,488	1,651	27,161	16.45	11
12	Dietician					12
13	Food Service Supervisor	1,917	2,069	46,298	22.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,918	19,716	183,767	9.32	15
16	Dishwashers					16
17	Maintenance Workers	11,129	12,042	148,205	12.31	17
18	Housekeepers	14,949	16,274	145,652	8.95	18
19	Laundry	5,408	5,695	51,606	9.06	19
20	Administrator	2,712	2,904	116,124	39.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,712	6,107	81,997	13.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care Plan Cordina	2,599	2,731	82,517	30.21	32
33	Other(specify) Marketing	2,913	3,329	74,826	22.48	33
34	TOTAL (lines 1 - 33)	192,748	207,956	$ 2,803,441 *	$ 13.48	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	172	$ 6,882	1(3)	35
36	Medical Director	120	21,600	9(3)	36
37	Medical Records Consultant			10(3)	37
38	Nurse Consultant			10(3)	38
39	Pharmacist Consultant	144	7,211	10(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	53	1,302	11(3)	44
45	Social Service Consultant	117	2,914	12(2)	45
46	Other(specify) Administrative	364	17,150	21(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	970	$ 57,059		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	116	$ 6,050	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	116	$ 6,050		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Hufsey	Administrator	0	$ 116,124
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 116,124

B. Administrative - Other

Description	Amount
Management Fees "Eliminated in Col. 7"	$ 307,835
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 307,835

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 75,657
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 75,657

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,342
Unemployment Compensation Insurance	32,124
FICA Taxes	193,205
Employee Health Insurance	34,075
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	179
Other Employee Benefits	3,042
TOTAL (agree to Schedule V, line 22, col.8)	$ 320,967

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,306
Health Care Worker Background Check	
(Indicate # of checks performed 115)	1,324
Patient Background Checks 162	1,948
Illinois Council on Long Term Care	13,416
St. Anthony's Petty Cash	141
Miscellaneous Licenses & Fees	6,524
Allocated from Home Office	1,939
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,598

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	523
Allocated from Home Office	22,676
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,199

**See instructions.

St. Anthony's Nursing & Rehab Center
Provider #: 0047126
01/01/11 - 12/31/11

Schedule 21A

XIX.C. Professional Services

Vendor/Payee	Type	Amount
Xcel Supply LLC	Legal Fees	401
Shaw Gussis Fishman Glanz Wolfson & To	Legal Fees	743
McGladrey & Pullen LLP-Cost Reports	Accounting Fee	1,113
RSM McGladrey Inc.-Taxes	Accounting Fee	4,150
Sharon Haugh Lofgren	Accounting Fee	3,600
Govig and Associates Inc.	Consulting Fee	8,000
Healthcare Capital Funding, LLC	Consulting Fee	7,500
Kay Wallin- Consulting	Consulting Fee	4,478
Midwest Renovation & Restoration Inc.	Consulting Fee	24,944
Richard Peelo & Associates Inc.	Consulting Fee	4,200
Ivans Inc.	Data Processing	2,063
Payday-USA	Data Processing	4,434
Health Data Systems Inc.	Data Processing	6,538
LTC Solutions Inc.	Data Processing	1,821
Alpha Data Services LLC	Data Processing	(20)
ADP	Data Processing	253
Emdeon Business Services-Medifax	Data Processing	19
Total for Page 3, Line 19, Column 3	Total	74,237 To PG21
Allocation from Mgmt. Co.		44,453
Total for Page 3, Line 19, Column 8		118,690

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report Period Beginning: 01/01/2011 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			$		$	$	$	$	$	$	$	$	$
2													
3									N/A				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St. Anthony's Nursing & Rehab Center # 0047126 Report 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? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $13,416**

(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? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,620** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **71,175**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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? **No**
Attach invoices and a summary of services for all architect and appraisal fees