

		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: <u>0050997</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Marion Rehabilitation and Nursing Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1301 East Deyoung</u> <u>Marion</u> <u>62959</u>																									
Number City Zip Code																									
County: <u>Williamson County</u>																									
Telephone Number: <u>(708) 236-0000</u> Fax # <u>(708) 236-0001</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Steven Blisko</u></td></tr><tr><td>(Title) <u>Manager</u></td></tr><tr><td>(Signed) <u>See Accountants' Compilation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Dan Gaafar Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Indianapolis, IN 46225</u></td></tr><tr><td>(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Steven Blisko</u>	(Title) <u>Manager</u>	(Signed) <u>See Accountants' Compilation Report</u>	Paid Preparer	(Print Name and Title) <u>Dan Gaafar Partner</u>	(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Indianapolis, IN 46225</u>	(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>06/01/10</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Dan Gaafar</u> Telephone Number: <u>(317) 237-5503</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Marion Rehabilitation and Nursing Center

0050997 Report Period Beginning: 1/1/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	125	Skilled (SNF)	125	45,625	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	125	TOTALS	125	45,625	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	23,933	4,005	5,482	33,420	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,933	4,005	5,482	33,420	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.25%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

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 06/01/10

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

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 53 and days of care provided 5,156

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

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

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

STATE OF ILLINOIS														
Facility Name & ID Number		Marion Rehabilitation and Nursing Center				#	0050997		Report Period Beginning:		1/1/11	Ending:	Page 3	12/31/11
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)														
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY				
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10			
	A. General Services													
1	Dietary	211,550	13,663	7,622	232,835		232,835	(106)	232,729				1	
2	Food Purchase		179,448		179,448		179,448		179,448				2	
3	Housekeeping	181,858	22,883		204,741		204,741		204,741				3	
4	Laundry	79,681	14,136		93,817		93,817		93,817				4	
5	Heat and Other Utilities			129,997	129,997		129,997	2,929	132,926				5	
6	Maintenance	24,682	17,767	18,561	61,010		61,010	14	61,024				6	
7	Other (specify):*												7	
8	TOTAL General Services	497,771	247,897	156,180	901,848		901,848	2,837	904,685				8	
	B. Health Care and Programs													
9	Medical Director			4,800	4,800		4,800		4,800				9	
10	Nursing and Medical Records	1,137,143	61,852	26,017	1,225,012		1,225,012	247	1,225,259				10	
10a	Therapy			661,301	661,301		661,301		661,301				10a	
11	Activities	62,277	7,458		69,735		69,735		69,735				11	
12	Social Services	30,319		5,365	35,684		35,684		35,684				12	
13	CNA Training												13	
14	Program Transportation												14	
15	Other (specify):* Pharmacy Consultant			4,715	4,715		4,715		4,715				15	
16	TOTAL Health Care and Programs	1,229,739	69,310	702,198	2,001,247		2,001,247	247	2,001,494				16	
	C. General Administration													
17	Administrative	46,270			46,270		46,270		46,270				17	
18	Directors Fees												18	
19	Professional Services			197,783	197,783		197,783	(161,175)	36,608				19	
20	Dues, Fees, Subscriptions & Promotions			2,456	2,456		2,456	146	2,602				20	
21	Clerical & General Office Expenses	62,574	36,324	20,468	119,366		119,366	90,315	209,681				21	
22	Employee Benefits & Payroll Taxes			375,003	375,003		375,003	20,316	395,319				22	
23	Inservice Training & Education												23	
24	Travel and Seminar			3,038	3,038		3,038	5,131	8,169				24	
25	Other Admin. Staff Transportation												25	
26	Insurance-Prop.Liab.Malpractice			77,032	77,032		77,032	327	77,359				26	
27	Other (specify):*												27	
28	TOTAL General Administration	108,844	36,324	675,780	820,948		820,948	(44,940)	776,008				28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,836,354	353,531	1,534,158	3,724,043		3,724,043	(41,856)	3,682,187				29	

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			304,130	304,130		304,130	(257,524)	46,606			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			5,828	5,828		5,828	(539)	5,289			32
33	Real Estate Taxes			59,053	59,053		59,053		59,053			33
34	Rent-Facility & Grounds			701,923	701,923		701,923	4,498	706,421			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,071,749	1,071,749		1,071,749	(253,565)	818,184			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,173		152,173		152,173		152,173			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,755	79,755		79,755		79,755			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		152,173	79,755	231,928		231,928		231,928			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,836,354	505,704	2,685,662	5,027,720		5,027,720	(295,421)	4,732,299			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(258,847)	30		9
10	Interest and Other Investment Income	(786)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(106)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,350)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (264,089)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(31,332)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31,332)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (295,421)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: ID# 0050997

Ending: 1/1/11

12/31/11

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

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven Blisko	70	Anna Rehab & Nursing Center	Anna	Senior Healthcare	Skokie	Management Co
A&F General Partnership	25	Carbondale Rehab & Nursing	Carbondale			
Ted Lerman	5	Cobden Rehab & Nursing	Cobden			
		Herrin Rehab & Nursing	Herrin			
		Ridgway Rehab & Nursing	Ridgway			
		Alton Rehab & Nursing	Alton			
		Chester Rehab & Nursing	Chester			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing Wages	\$ 26,017	Senior Healthcare Management	100.00%	\$ 26,264	\$ 247	1
2	V	21	Admin Wages	2,706	Senior Healthcare Management		92,983	90,277	2
3	V	5	Utilities		Senior Healthcare Management		2,929	2,929	3
4	V	19	Professional Services	180,000	Senior Healthcare Management		18,825	(161,175)	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Senior Healthcare Management		146	146	5
6	V	21	Clerical & General Office Expense	2,686	Senior Healthcare Management		1,633	(1,053)	6
7	V	22	Employee Benefits & Payroll Taxes		Senior Healthcare Management		20,316	20,316	7
8	V	24	Travel and Seminar	51	Senior Healthcare Management		5,182	5,131	8
9	V	26	Insurance-Prop.Liab.Malpractice		Senior Healthcare Management		327	327	9
10	V	30	Depreciation		Senior Healthcare Management		1,323	1,323	10
11	V	32	Interest		Senior Healthcare Management		247	247	11
12	V	34	Rent-Facility & Grounds		Senior Healthcare Management		4,498	4,498	12
13	V	6	Repairs & Maintenance		Senior Healthcare Management		14	14	13
14	Total			\$ 211,460			\$ 174,687	\$ * (36,773)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Office Supplies	\$ 1,150	Senior Healthcare Management		\$ 6,591	\$ 5,441	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,150			\$ 6,591	\$ * 5,441	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Marion Rehabilitation and Nursing Center # 0050997 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$		\$			\$	1						
2													2						
3													3						
4													4						
5													5						
	Working Capital																		
6	Bank Leumi USA		X	Working Capital		8/1/11	3,400,000	700,000	8/1/12	4.5000	5,828	6							
7												7							
8												8							
9	TOTAL Facility Related							\$ 3,400,000	\$ 700,000			\$ 5,828	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$	\$			\$	14						
15	TOTALS (line 9+line14)							\$ 3,400,000	\$ 700,000			\$ 5,828	15						

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	(23,750)	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.)		\$	58,516	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	82,266	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(11,896)	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.		\$	70,370	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009	59,198	11	
		2010	58,516	12	
				13	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Marion Rehabilitation and Nursing Center

COUNTY

Williamson County

FACILITY IDPH LICENSE NUMBER

0050997

CONTACT PERSON REGARDING THIS REPORT

Daniel S. Gaafar

TELEPHONE

(317) 237-5500

FAX #:

(317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>07-17-151-001</u>	<u>Nursing Facility</u>	\$ <u>58,515.78</u>	\$ <u>58,515.78</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>58,515.78</u>	\$ <u>58,515.78</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,500

B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 12,225

2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 815

4. Dates Incurred: Prior to 6/1/10

Nature of Costs: Organizational Costs

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	125				\$	\$		\$	\$	4	
5										5	
6										6	
7										7	
8										8	
	Improvement Type**										
9	Windows & Doors			6/1/2010	5,700	147	39	147		231	9
10	Humidifier			6/1/2010	676	17	39	17		27	10
11	Heating & Cooling System			6/1/2010	2,434	62	39	62		98	11
12	Heating System			6/1/2010	5,949	153	39	153		242	12
13	Heating System			6/1/2010	1,082	28	39	28		45	13
14	Fire Sprinklers			2011	10,018	235	39	235		235	14
15	Fire Sprinklers			2011	75,795	972	39	972		972	15
16	Roof Repairs			2011	9,750	167	39	167		167	16
17	Panelling			2011	9,398	100	39	100		100	17
18	Exterior work: columns, access panel, sconces, soffit			2011	30,000	385	39	385		385	18
19	Lobby:Demolition, Lighting/Electrical, Painting, Flooring,										19
20	Trim, Millwork			2011	101,615	1,303	39	1,303		1,303	20
21	Wall covering & ceiling tiles in Admissions office			2011	7,735	99	39	99		99	21
22	Nurses Station: wallpaper, reface desk, lighting, painting			2011	21,087	270	39	270		270	22
23	Flooring & Painting Vestibule			2011	5,687	73	39	73		73	23
24	Lighting, wallpaper, floor tile, kitchen cabinets for diniing			2011	31,194	400	39	400		400	24
25	Additional parking spots/ asphalt			2011	61,666	791	39	791		791	25
26	Rewire failing door closures			2011	3,800	49	39	49		49	26
27	Refinish doors			2011	16,500	212	39	212		212	27
28	New ceiling tiles & basket lighting fixtures			2011	16,000	205	39	205		205	28
29	New windows & glass door			2011	27,000	346	39	346		346	29
30	Install EIFS and paint			2011	68,000	872	39	872		872	30
31	Custom exterior sign			2011	19,000	244	39	244		244	31
32	PTAC units			2011	38,000	487	39	487		487	32
33	New kitchen tile			2011	10,800	138	39	138		138	33
34	Steel Valve			2011	2,300	29	39	29		29	34
35	Hot water Boilers Repair			2011	2,000	26	39	26		26	35
36	Roof engineering fee			2011	4,500	58	39	58		58	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

Facility Name & ID Number Marion Rehabilitation and Nursing Center

0050997

Report Period Beginning:

1/1/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Resident Rooms: door handles, ceiling tiles, paint, flooring,		\$	\$		\$	\$	\$	37
38	lighting fixtures	2011	138,348	1,774	39	1,774		1,774	38
39	Corridors: handrails, signs, doors, ceiling tiles, lighting	2011	130,900	1,678	39	1,678		1,678	39
40	Windows & Painting of Laundry Room	2011	3,300	42	39	42		42	40
41	HVACs	2011	32,400	415	39	415		415	41
42	Landscaping	2011	12,500	160	39	160		160	42
43	Drainage	2011	4,600	59	39	59		59	43
44	Custom laminate nurses station	2011	16,900	217	39	217		217	44
45	Restrooms: Molding, chair rail, door, tile, paint, toilets, mirror	2011	22,000	282	39	282		282	45
46	Whirlpool Tub, plumbing, wall tiles	2011	12,000	154	39	154		154	46
47	Shower room: door, tile, paint, shower stalls, bathtub, lights	2011	55,000	705	39	705		705	47
48	Patio: concrete, doors, drainage	2011	41,600	533	39	533		533	48
49	Dining: Molding, chair rail, ceiling tiles, wallcoverng, signs	2011	50,535	648	39	648		648	49
50	New doors and walls in medicine storage room	2011	6,000	77	39	77		77	50
51	Storage Room: new wall, door and paint	2011	5,500	71	39	71		71	51
52	Toilets, sinks, mirrors, lighting grab bars in resd bathrooms	2011	30,000	385	39	385		385	52
53	Roof	2011	83,000	1,064	39	1,064		1,064	53
54	Toilets, sinks, mirrors, lighting grab bars in resd bathrooms	2011	10,000	128	39	128		128	54
55	Call Bell System and Wander Mangagment System	2011	61,000	782	39	782		782	55
56	Med room& MOP : closet door, sink, counter, lighting, paint	2011	5,700	73	39	73		73	56
57	Bathroom: flooring, sink, toilet, lighting, grab bars. Paint	2011	4,100	53	39	53		53	57
58	Concrete patio	2011	6,300	81	39	81		81	58
59	Sink room: tile, backsplash, paint, countertops, cabinets	2011	4,000	51	39	51		51	59
60	Woodlock Kick Plates	2011	7,900	101	39	101		101	60
61	Refinish nurse station, quartz countertop	2011	5,300	68	39	68		68	61
62	Flooring for vestibule	2011	2,300	29	39	29		29	62
63	Seating Areas: door, paint, lighting, ceiling tile, drywall, flooring	2011	8,100	104	39	104		104	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,346,969	\$ 17,601		\$ 17,601	\$	\$ 17,837	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$11,239	\$	\$2,248	\$2,248	5	\$11,239	71
72	Current Year Purchases	286,529	286,529	26,757	(259,772)	5	286,529	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$297,768	\$286,529	\$29,005	\$(257,524)		\$297,768	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	2	
	Reference	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)	\$1,644,737	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$304,130	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$46,606	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(257,524)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$315,605	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Southern Illinois Healthcare Realty, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:	1995	68	5/28/10	\$ 701,923	20		3
4	Additions	2001	57					4
5								5
6								6
7	TOTAL		125		\$ 701,923			7

**

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

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

N/A

N/A

9. Option to Buy:

☒ YES

☐ NO

 Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO
16. Rental Amount for movable equipment: \$ N/A Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 6/1/10

Ending 5/31/30

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

	Fiscal Year Ending	Annual Rent
12.	12/31/12	\$ 740,947
13.	12/31/13	\$ 770,552
14.	12/31/14	\$ 805,019

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		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-3	hrs	\$		\$ 302,583	\$		\$ 302,583	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			61,426			61,426	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			297,292			297,292	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				142,208		142,208	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology & Lab	39-2					9,965		9,965	13
14	TOTAL			\$		\$ 661,301	\$ 152,173		\$ 813,474	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 37,228	\$ 37,228	1
2	Cash-Patient Deposits	(3,813)	(3,813)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,879,045	1,879,045	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,912,460	\$ 1,912,460	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	1,346,968	1,346,968	15
16	Equipment, at Historical Cost	297,768	297,768	16
17	Accumulated Depreciation (book methods)	(315,605)	(315,605)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,290)	(1,290)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,340,066	\$ 1,340,066	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,252,526	\$ 3,252,526	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 855,738	\$ 855,738	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,886	169,886	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital Loan	700,000	700,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,725,624	\$ 1,725,624	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)	\$ 1,725,624	\$ 1,725,624	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,526,902	\$ 1,526,902	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,252,526	\$ 3,252,526	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 755,469	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 755,469	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,221,433	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	(450,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 771,433	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)	\$ 1,526,902	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,814,545	1
2	Discounts and Allowances for all Levels	167,113	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,981,658	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,817	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 216,817	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	46,625	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,515	19
20	Radiology and X-Ray	752	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,892	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	786	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 786	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,249,153	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	901,848	31
32	Health Care	2,001,247	32
33	General Administration	820,948	33
	B. Capital Expense		
34	Ownership	1,071,749	34
	C. Ancillary Expense		
35	Special Cost Centers	152,173	35
36	Provider Participation Fee	79,755	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,027,720	40
41	Income before Income Taxes (line 30 minus line 40)**	1,221,433	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,221,433	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,026	2,144	\$ 56,443	\$ 26.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,792	4,889	96,277	19.69	3
4	Licensed Practical Nurses	22,190	23,026	345,052	14.99	4
5	CNAs & Orderlies	60,192	62,213	592,260	9.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,447	6,631	62,277	9.39	9
10	Activity Assistants					10
11	Social Service Workers	1,955	2,122	30,319	14.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,398	24,487	211,550	8.64	15
16	Dishwashers					16
17	Maintenance Workers	2,067	2,281	24,682	10.82	17
18	Housekeepers	20,166	21,565	181,858	8.43	18
19	Laundry	8,921	9,588	79,681	8.31	19
20	Administrator	1,957	2,168	46,270	21.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,675	6,965	62,574	8.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS	2,349	2,552	47,111	18.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,135	170,631	\$ 1,836,354 *	\$ 10.76	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	218	\$ 7,622	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	94	4,715	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	153	5,365	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	465	\$ 17,702		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
Marion Rehabilitation and Nursing Center

0050997

Report Period Beginning: 1/1/11

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Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Leeann Ward

Admin

0

\$ 46,270

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 46,270

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

Senior Healthcare

Professional

\$ 180,000

Accrued Expenses

Accounting

2,000

Bradley Associates

Accounting

10,446

Meyer Magence

Legal

5,337

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 197,783

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 165,585

Unemployment Compensation Insurance

43,710

FICA Taxes

148,875

Employee Health Insurance

16,236

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Employee Expense

20,913

TOTAL (agree to Schedule V, line 22, col.8)

\$ 395,319

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 2,356

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed)

Patient Background Checks

Senior Healthcare License/Dues/Fees

146

Misc License & Fees

100

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 2,602

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Auto Allowance

1,154

Mileage

837

Senior Healthcare Travel Exp

5,040

Seminar Expense

Education

996

Meals

142

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 8,169

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. No

(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?
What was the average life used for new equipment added during this period? Yes
5 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A

(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?
If YES, give effective date of lease. No

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
\$ 79,755
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?
N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs?
No Indicate the amount. \$ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
No If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
No If YES, please indicate the amount of income earned from such a program during this reporting period. \$
c. What percent of all travel expense relates to transportation of nurses and patients?
100%
d. Have vehicle usage logs been maintained?
N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
Yes
g. Does the facility transport residents to and from day training?
No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT