



Facility Name & ID Number City Care Center of Cobden

# 0041491 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	16	Skilled (SNF)	16	5,856	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	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	1,500	175	1,040	2,715	8
9	SNF/PED					9
10	ICF	13,372	1,537	2,322	17,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,872	1,712	3,362	19,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.64%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 12/01/95

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 12/01/95 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 10 and days of care provided 1,040

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/08 Ending: 12/31/08

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
	<b>A. General Services</b>										
1	Dietary	108,292	9,187	4,248	121,727		121,727	121,727			1
2	Food Purchase		101,057		101,057	(4,000)	97,057	97,057			2
3	Housekeeping	123,464	9,184	4,618	137,266		137,266	137,266			3
4	Laundry	30,573	7,885		38,458		38,458	38,458			4
5	Heat and Other Utilities			62,726	62,726		62,726	62,726			5
6	Maintenance	37,282		31,795	69,077		69,077	69,077			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	299,611	127,313	103,387	530,311	(4,000)	526,311	526,311			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,200	9,200		9,200	9,200			9
10	Nursing and Medical Records	562,039	61,995	1,100	625,134		625,134	625,134			10
10a	Therapy										10a
11	Activities	35,979	1,293	208	37,480		37,480	37,480			11
12	Social Services	24,795		3,936	28,731		28,731	28,731			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	622,813	63,288	14,444	700,545		700,545	700,545			16
	<b>C. General Administration</b>										
17	Administrative	52,116			52,116		52,116	35,968	88,084		17
18	Directors Fees										18
19	Professional Services			72,108	72,108		72,108	(60,567)	11,541		19
20	Dues, Fees, Subscriptions & Promotions			4,949	4,949		4,949	(2,183)	2,766		20
21	Clerical & General Office Expenses	21,520	21,334	27,574	70,428		70,428	75,476	145,904		21
22	Employee Benefits & Payroll Taxes			167,063	167,063	4,000	171,063		171,063		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,854	1,854		1,854		1,854		24
25	Other Admin. Staff Transportation			694	694		694		694		25
26	Insurance-Prop.Liab.Malpractice			60,917	60,917		60,917		60,917		26
27	Other (specify):* <b>Allocated Benefits</b>							14,737	14,737		27
28	<b>TOTAL General Administration</b>	73,636	21,334	335,159	430,129	4,000	434,129	63,431	497,560		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	996,060	211,935	452,990	1,660,985		1,660,985	63,431	1,724,416		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 City Care Center of Cobden #0041491 Report Period Beginning: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	<b>D. Ownership</b>										
30	Depreciation			9,031	9,031	9,031	10,678	19,709			30
31	Amortization of Pre-Op. & Org.						29,172	29,172			31
32	Interest			27,881	27,881	27,881	142,948	170,829			32
33	Real Estate Taxes						27,588	27,588			33
34	Rent-Facility & Grounds			265,553	265,553	265,553	(258,907)	6,646			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			302,465	302,465	302,465	(48,521)	253,944			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,626	40,626	40,626		40,626			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			40,626	40,626	40,626		40,626			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	996,060	211,935	796,081	2,004,076	2,004,076	14,910	2,018,986			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 City Care Center of Cobden

# 0041491

Report Period Beginning: 01/01/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,474)	30		9
10	Interest and Other Investment Income	(367)	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	(2,183)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,064)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule ABS Mgmt	(61,000)	19		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (66,088)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(52,728)		34
35	Other- Attach Schedule Allocate Indirect Costs	133,726		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 80,998		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 14,910		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

City Care Center of Cobden

ID# 0041491

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number City Care Center of Cobden

# 0041491

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,183)	0	0	0	0	0	0	0	0	0	0	(2,183)	20
21	Clerical & General Office Expenses	(1,064)	598	0	0	0	0	0	0	0	0	0	(466)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(3,247)</b>	<b>598</b>	<b>0</b>	<b>(2,649)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(3,247)</b>	<b>598</b>	<b>0</b>	<b>(2,649)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number City Care Center of Cobden

# 0041491

Report Period Beginning:

01/01/08 Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,474)	12,152	0	0	0	0	0	0	0	0	0	10,678	30
31	Amortization of Pre-Op. & Org.	0	29,172	0	0	0	0	0	0	0	0	0	29,172	31
32	Interest	(367)	143,315	0	0	0	0	0	0	0	0	0	142,948	32
33	Real Estate Taxes	0	27,588	0	0	0	0	0	0	0	0	0	27,588	33
34	Rent-Facility & Grounds	0	(265,553)	0	0	0	0	0	0	0	0	0	(265,553)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,841)</b>	<b>(53,326)</b>	<b>0</b>	<b>(55,167)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(5,088)</b>	<b>(52,728)</b>	<b>0</b>	<b>(57,816)</b>	<b>45</b>								

Facility Name & ID Number City Care Center of Cobden

# 0041491

Report Period Beginning:

01/01/08

Ending:

12/31/08

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		Cobden, LLC	Cobden	Bldg Rental
				ABS Management	Chicago	Management

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 265,553	The Willow of Cobden, LLC	100.00%	\$	(265,553)	1
2	V	32 Interest		The Willow of Cobden, LLC		143,315	143,315	2
3	V	33 Real Estate Tax		The Willow of Cobden, LLC		27,588	27,588	3
4	V	21 Office		The Willow of Cobden, LLC		598	598	4
5	V	30 Depreciation		The Willow of Cobden, LLC		12,152	12,152	5
6	V	31 Amortization		The Willow of Cobden, LLC		29,172	29,172	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 265,553			\$ 212,825	\$ * (52,728)	14

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

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	David Abell		Administrative	11.00	104,898	5.25	10.50	ABS Salary	\$ 15,102	17-7	1
2	Tamar Abell		Administrative	11.00	34,966	3.75	7.50	ABS Salary	5,034	17-7	2
3	Joseph Brandman		Administrative	22.00	109,966	4.25	8.75	ABS Salary	15,832	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 35,968		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 City Care Center of Cobden

# 0041491

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 ABS Management  
 Street Address 2711 W. Howard  
 City / State / Zip Code Chicago, IL 60645  
 Phone Number ( 773-338-4400  
 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	17	David Abell	588		\$ 120,000	\$ 120,000	74	\$ 15,102	1
2	17	Tamar Abell	588		40,000	40,000	74	5,034	2
3	17	Joseph Brandman	588		125,798	125,798	74	15,832	3
4	21	Clerical	588		411,237	411,237	74	51,754	4
5	34	Rent	588		52,809		74	6,646	5
6	27	Payroll Taxes	588		47,774		74	6,012	6
7	27	Health & Welfare	588		69,332		74	8,725	7
8	19	Professional Fees	588		3,440		74	433	8
9	21	Office	588		192,195		74	24,188	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				\$ 1,062,585	\$ 697,035		\$ 133,726	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Chase		X	Mortgage	\$21,444.90	7/24/98	\$ 2,600,000	\$ 0	7/24/08	7.6800	\$ 106,149	1								
2	US Bank		X	Mortgage	\$16,289.92	10/10/08	2,304,811	2,297,993	10/09/13	7.0000	37,166	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MB Financial		X	Working Capital		4/16/03	200,000	0		8.5000	24,778	6								
7	US Bank		X	Working Capital			318,489	318,489	10/09/13	7.0000	3,103	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$37,734.82		\$ 5,423,300	\$ 2,616,482			\$ 171,196	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(367)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(367)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 5,423,300	\$ 2,616,482			\$ 170,829	15								

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

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

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





Facility Name & ID Number City Care Center of Cobden

# 0041491 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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

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

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

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

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

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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: 455,180 2. Number of Years Over Which it is Being Amortized: 15  
3. Current Period Amortization: 29,172 4. Dates Incurred: 12/1/95

Nature of 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	<u>Facility</u>		<u>1995</u>	<u>\$ 15,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 15,000</b>	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1995		\$ 475,200	\$ 12,152	39	\$ 12,152	\$	\$ 157,976	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		Generator		1998	10,130	260	39	260		2,654	9
10		Remodeling-Addition of Dining Room & Rec Room									10
11		Site Preparation		1999	60,320	1,547	39	1,547		14,245	11
12		Concrete, Masonery, Drywall		1999	50,469	1,294	39	1,294		11,916	12
13		Caprentry		1999	25,069	643	39	643		5,921	13
14		Electrical		1999	20,340	522	39	522		4,807	14
15		Heating, Ventilation & Air Conditioning		1999	9,693	249	39	249		2,293	15
16		Plumbing		1999	11,326	290	39	290		2,670	16
17		Flooring		1999	2,280	58	39	58		534	17
18		Painting		1999	4,100	105	39	105		967	18
19		Sprinkler System		1999	13,100	336	39	336		3,094	19
20		Doors & Hardware		1999	8,886	228	39	228		2,099	20
21		Aluminum Railing		1999	11,630	298	39	298		2,744	21
22		Tiling		2002	11,378	292	39	292		1,971	22
23		Remodeling-Halls		2003	11,945	307	39	307		1,688	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 City Care Center of Cobden

# 0041491

Report Period Beginning:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 725,866	\$ 18,581		\$ 18,581	\$	\$ 215,579	70

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

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 11,284	\$ 2,602	\$ 1,128	\$ (1,474)	10	\$ 3,384	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	75,000				10	75,000	73
74								74
75	TOTALS	\$ 86,284	\$ 2,602	\$ 1,128	\$ (1,474)		\$ 78,384	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	1998	\$ 5,976	\$	\$	\$		\$ 5,976	76
77										77
78										78
79										79
80	TOTALS			\$ 5,976	\$	\$	\$		\$ 5,976	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)	\$ 833,126	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,183	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,709	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,474)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 299,939	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: \_\_\_\_\_

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:				\$ _____			3
4	Additions				_____			4
5	Allocation From ABS Management				6,646			5
6					_____			6
7	TOTAL				\$ 6,646			7

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

9. Option to Buy:  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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist		hrs	\$				\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	<b>TOTAL</b>			\$				\$		\$			\$			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 City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (107,309)	\$ (107,086)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	719,799	719,799	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,621	58,621	6
7	Other Prepaid Expenses	508,384	486,384	7
8	Accounts Receivable (owners or related parties)	1,000		8
9	Other(specify): <u>Due From Others</u>	452,366	1,750,930	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,632,861	\$ 2,908,648	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		15,000	13
14	Buildings, at Historical Cost		475,200	14
15	Leasehold Improvements, at Historical Cost	250,666	250,666	15
16	Equipment, at Historical Cost	11,284	86,284	16
17	Accumulated Depreciation (book methods)	(64,580)	(299,342)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		437,580	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(374,566)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 197,370	\$ 590,822	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,830,231	\$ 3,499,470	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 134,949	\$ 149,949	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	318,489	318,489	29
30	Accrued Salaries Payable	31,814	31,814	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,513	4,513	31
32	Accrued Real Estate Taxes(Sch.IX-B)		13,146	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to LLC</u>	111,803		36
37	<u>Due to Others</u>	165,000		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 766,568	\$ 517,911	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,297,993	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 2,297,993	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 766,568	\$ 2,815,904	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,098,843	\$ 683,566	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,865,411	\$ 3,499,470	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 966,917	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 966,917	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	131,926	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 131,926	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,098,843	24 *

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

Facility Name & ID Number City Care Center of Cobden

# 0041491

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,135,635	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,135,635	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	367	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 367	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,136,002	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	530,311	31
32	Health Care	700,545	32
33	General Administration	430,129	33
<b>B. Capital Expense</b>			
34	Ownership	302,465	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	40,626	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,004,076	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	131,926	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 131,926	43

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

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

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

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

Facility Name & ID Number City Care Center of Cobden

# 0041491

Report Period Beginning: 01/01/08

Ending:

12/31/08

**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	2,010	2,290	\$ 42,482	\$ 18.55	1
2	Assistant Director of Nursing	2,968	2,992	39,087	13.06	2
3	Registered Nurses	1,897	1,900	31,974	16.83	3
4	Licensed Practical Nurses	8,521	8,534	109,837	12.87	4
5	CNAs & Orderlies	41,126	41,147	338,659	8.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,457	3,457	27,378	7.92	9
10	Activity Assistants	1,127	1,127	8,601	7.63	10
11	Social Service Workers	2,452	2,452	24,795	10.11	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,417	22,677	9.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,199	11,200	85,615	7.64	15
16	Dishwashers					16
17	Maintenance Workers	3,712	4,080	37,282	9.14	17
18	Housekeepers	16,803	16,803	123,464	7.35	18
19	Laundry	3,825	3,825	30,573	7.99	19
20	Administrator	2,112	2,264	52,116	23.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,184	2,192	21,520	9.82	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,457	106,680	\$ 996,060 *	\$ 9.34	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	75	\$ 4,248	1-3	35
36	Medical Director	95	9,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	20	1,100	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	6	208	11-3	44
45	Social Service Consultant	75	3,936	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	271	\$ 18,692		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

Facility Name & ID Number City Care Center of Cobden

# 0041491

Report Period Beginning: 01/01/08

Ending: 12/31/08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Terri Pasquino</u>	<u>Administrator</u>		\$ <u>52,116</u>	<u>Workers' Compensation Insurance</u>	\$ <u>61,579</u>	<u>IDPH License Fee</u>	\$ <u>990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>14,275</u>	<u>Advertising: Employee Recruitment</u>	<u>581</u>	
				<u>FICA Taxes</u>	<u>76,199</u>	<u>Health Care Worker Background Check</u>	<u>500</u>	
				<u>Employee Health Insurance</u>	<u>15,010</u>	(Indicate # of checks performed <u>50</u> )		
				<u>Employee Meals</u>	<u>4,000</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Advertising</u>	<u>2,183</u>	
						<u>Various</u>	<u>695</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>52,116</u>			<b>Less: Public Relations Expense</b>	<u>(2,183)</u>	
<b>(List each licensed administrator separately.)</b>						<b>Non-allowable advertising</b>	<u>( )</u>	
<b>B. Administrative - Other</b>						<b>Yellow page advertising</b>	<u>( )</u>	
<b>Description</b>			<b>Amount</b>			<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
			\$				\$ <u>2,766</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <u>171,063</u>			
<b>(Attach a copy of any management service agreement)</b>								
C. Professional Services			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
<u>Mendel S Schneider</u>	<u>Accounting</u>	\$ <u>4,800</u>			\$	<u>Out-of-State Travel</u>	\$	
<u>Richard Peelo</u>	<u>Accounting</u>	<u>4,550</u>						
<u>ABS Management</u>	<u>Home Office- Adj out</u>	<u>61,000</u>						
<u>Personnel Planners</u>	<u>UC Tax Consultant</u>	<u>1,190</u>				<u>In-State Travel</u>		
<u>Reedsmith</u>	<u>Legal</u>	<u>568</u>						
						<u>Seminar Expense</u>		
						<u>ICLTC</u>	<u>1,854</u>	
						<b>Entertainment Expense</b>	<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>72,108</u>	<b>TOTAL</b>	\$	<b>(agree to Sch. V, line 24, col. 8)</b>		
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							\$ <u>1,854</u>	

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,500 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,626  
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. \$ 4,000 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? 0  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.