

		FOR BHF USE				

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0046276</u></p> <p>Facility Name: <u>METROPOLIS NURSING & REHAB CTR</u></p> <p>Address: <u>2299 METROPOLIS STREET</u> <u>METROPOLIS</u> <u>62960</u> <small>Number City Zip Code</small></p> <p>County: <u>MASSAC</u></p> <p>Telephone Number: <u>618-524-2634</u> Fax # <u>618-524-2507</u></p> <p>HFS ID Number: <u>37-0859225002</u></p> <p>Date of Initial License for Current Owners: <u>1/1/1965</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input checked="" type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>KEN MARX</u> Telephone Number: <u>314-231-5544</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/08</u> to <u>12/31/08</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>SCOTT BIRK, SR. V.P., THSCLLS, MGMT. CO.</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) <u>KEN MARX PARTNER</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) <u>BKD, LLP 501 N. BROADWAY, STE. 600</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>314-231-5544</u> Fax # <u>314-231-9731</u></td> </tr> </table> <p style="font-size: small; margin-top: 10px;"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>SCOTT BIRK, SR. V.P., THSCLLS, MGMT. CO.</u>		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>KEN MARX PARTNER</u>		(Firm Name & Address) <u>BKD, LLP 501 N. BROADWAY, STE. 600</u>		(Telephone) <u>314-231-5544</u> Fax # <u>314-231-9731</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number METROPOLIS NURSING & REHAB CTR

0046276 Report Period Beginning: 1/1/08 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		Skilled (SNF)	90	32,940	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		TOTALS	90	32,940	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	16,809	8,464	
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,809	8,464	4,904	30,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.61%

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 - 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 7/1/1965

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 90 and days of care provided 4,904

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

STATE OF ILLINOIS

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR # 0046276 Report Period Beginning: 1/1/08 Ending: 12/31/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 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	158,149	17,267	9,565	184,981		184,981	(8,226)	176,755		1
2	Food Purchase		180,163		180,163		180,163	(724)	179,439		2
3	Housekeeping		16,386	79,530	95,916		95,916		95,916		3
4	Laundry		7,743	54,844	62,587		62,587		62,587		4
5	Heat and Other Utilities			128,958	128,958		128,958		128,958		5
6	Maintenance	39,091	13,753	45,500	98,344		98,344		98,344		6
7	Other (specify):* TRASH REMOVAL			8,249	8,249		8,249		8,249		7
8	TOTAL General Services	197,240	235,312	326,646	759,198		759,198	(8,950)	750,248		8
B. Health Care and Programs											
9	Medical Director			3,664	3,664		3,664		3,664		9
10	Nursing and Medical Records	1,218,317	81,978	6,621	1,306,916		1,306,916		1,306,916		10
10a	Therapy		758	496,710	497,468		497,468		497,468		10a
11	Activities	42,540	661	12,860	56,061		56,061		56,061		11
12	Social Services	88,378	183	3,339	91,900		91,900		91,900		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,349,235	83,580	523,194	1,956,009		1,956,009		1,956,009		16
C. General Administration											
17	Administrative	66,166			66,166		66,166		66,166		17
18	Directors Fees										18
19	Professional Services			384,589	384,589		384,589	(300,119)	84,470		19
20	Dues, Fees, Subscriptions & Promotions			43,042	43,042		43,042	(24,991)	18,051		20
21	Clerical & General Office Expenses	106,573	19,575	69,868	196,016		196,016	146,931	342,947		21
22	Employee Benefits & Payroll Taxes			272,853	272,853		272,853		272,853		22
23	Inservice Training & Education			65	65		65		65		23
24	Travel and Seminar			5,362	5,362		5,362		5,362		24
25	Other Admin. Staff Transportation			9,954	9,954		9,954	(10,554)	(600)		25
26	Insurance-Prop.Liab.Malpractice			64,945	64,945		64,945	18,233	83,178		26
27	Other (specify):*										27
28	TOTAL General Administration	172,739	19,575	850,678	1,042,992		1,042,992	(170,500)	872,492		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,719,214	338,467	1,700,518	3,758,199		3,758,199	(179,450)	3,578,749		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.

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	
	D. Ownership											
30	Depreciation			30,646	30,646		30,646	109,564	140,210			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							190,907	190,907			32
33	Real Estate Taxes			71,523	71,523		71,523		71,523			33
34	Rent-Facility & Grounds			308,980	308,980		308,980	(301,489)	7,491			34
35	Rent-Equipment & Vehicles			850	850		850	3,701	4,551			35
36	Other (specify):*											36
37	TOTAL Ownership			411,999	411,999		411,999	2,683	414,682			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		206,526	49,051	255,577		255,577		255,577			39
40	Barber and Beauty Shops		81		81		81		81			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,572	56,572		56,572		56,572			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		206,607	105,623	312,230		312,230		312,230			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,719,214	545,074	2,218,140	4,482,428		4,482,428	(176,767)	4,305,661			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 METROPOLIS NURSING & REHAB CTR

0046276

Report Period Beginning: 1/1/08

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	(8,226)	1		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				9
10	Interest and Other Investment Income	(490)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(724)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(10,554)	25		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	(24,292)	21		24
25	Fund Raising, Advertising and Promotional	(24,991)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(411)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,688)		\$	30

BHF USE ONLY							
48		49	50	51	52		

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

		1	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)	(107,079)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (107,079)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (176,767)		37

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

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

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

STATE OF ILLINOIS
 METROPOLIS NURSING & REHAB CTR

ID# 0046276

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MISC.	\$ (411)	21	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
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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	(411)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR

0046276 Report Period Beginning:

1/1/08

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)	
	A. General Services													
1	Dietary	(8,226)	0	0	0	0	0	0	0	0	0	0	(8,226)	1
2	Food Purchase	(724)	0	0	0	0	0	0	0	0	0	0	(724)	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	TOTAL General Services	(8,950)	0	0	0	0	0	0	0	0	0	0	(8,950)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	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	(300,119)	0	0	0	0	0	0	0	0	0	(300,119)	19
20	Fees, Subscriptions & Promotions	(24,991)	0	0	0	0	0	0	0	0	0	0	(24,991)	20
21	Clerical & General Office Expenses	(24,703)	171,634	0	0	0	0	0	0	0	0	0	146,931	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	(10,554)	0	0	0	0	0	0	0	0	0	0	(10,554)	25
26	Insurance-Prop.Liab.Malpractice	0	18,233	0	0	0	0	0	0	0	0	0	18,233	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(60,248)	(110,252)	0	(170,500)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,198)	(110,252)	0	(179,450)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR # 0046276 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	109,564	0	0	0	0	0	0	0	0	0	109,564 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(490)	191,397	0	0	0	0	0	0	0	0	0	190,907 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(301,489)	0	0	0	0	0	0	0	0	0	(301,489) 34
35	Rent-Equipment & Vehicles	0	3,701	0	0	0	0	0	0	0	0	0	3,701 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(490)	3,173	0	2,683 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(69,688)	(107,079)	0	(176,767) 45								

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
TUTERA HEALTH SERVICES, LLC	100					
TI METROPOLIS, LLC- BLDG OWNER	100					

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	34 BUILDING & FIXTURES	\$	TUTERA HEALTH CARE SERVICES		\$ 7,491	\$ 7,491	1
2	V	35 MOVEABLE EQUIPMENT		TUTERA HEALTH CARE SERVICES		3,701	3,701	2
3	V	21 NON-CAPITAL		TUTERA HEALTH CARE SERVICES		166,114	166,114	3
4	V	19 PROFESSIONAL FEES	300,119	TUTERA HEALTH CARE SERVICES			(300,119)	4
5	V	30 DEPRECIATION		TI METROPOLIS, LLC		109,564	109,564	5
6	V	34 RENT	308,980	TI METROPOLIS, LLC			(308,980)	6
7	V	32 INTEREST		TI METROPOLIS, LLC		191,397	191,397	7
8	V	26 MORTGAGE INSURANCE PREMIUMS		TI METROPOLIS, LLC		18,233	18,233	8
9	V	21 ADMIN/ GENERAL		TI METROPOLIS, LLC		5,520	5,520	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 609,099			\$ 502,020	\$ * (107,079)	14

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

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR # 0046276 Report Period Beginning: 1/1/08 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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR # 0046276 Report Period Beginning: 1/1/08 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

Name of Related Organization TI METROPOLIS, LLC
 Street Address 7611 STATE LINE ROAD, STE 301
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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	24	NON CAPITAL	DIRECT COSTS	111,963,527	20	\$ 4,915,912	\$ 3,783,384	\$ 166,115	1
2	34	CAPITAL BUILDING	DIRECT COSTS	111,963,527	20	221,698	3,783,384	7,491	2
3	35	CAPITAL EQUIPMENT	DIRECT COSTS	111,963,527	20	109,528	3,783,384	3,701	3
4	30	DEPRECIATION	DIRECT COSTS	1		105,865	1	105,865	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					\$ 5,353,003	\$	\$ 283,172	25

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR # 0046276 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	TUTERA INVESTMENTS		X	WORKING CAPITAL			\$	421,269			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	INTEREST INCOME		X								411	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	421,269			\$	411	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	421,269			\$	411	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 **METROPOLIS NURSING & REHAB CTR**

0046276

Report Period Beginning: **1/1/08**

Ending: **12/31/08**

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 2007 report.		\$ 57,912		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.)		\$ 42,493		2
3.	Under or (over) accrual (line 2 minus line 1).		\$ (15,419)		3
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 86,942		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.		\$ 71,523		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2003	21,333	8	
		2004	64,000	9	
		2005	74,667	10	
		2006	66,038	11	
		2007	42,493	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2007 \$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME METROPOLIS NURSING & REHAB CTR COUNTY MASSAC

FACILITY IDPH LICENSE NUMBER 0046276

CONTACT PERSON REGARDING THIS REPORT JUNIOR FOSTER, THCSLLC, MGMT. CO.

TELEPHONE 816-444-0900 FAX #: 816-822-1723

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-36-300-006</u>	<u>LAND</u>	<u>\$ 42,492.58</u>	<u>\$ 42,492.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>42,492.58</u>	\$ <u>42,492.58</u>

B. Real Estate Tax Cost Allocation:

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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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: 42,793 B. General Construction Type: Exterior BRICK Frame BLOCK 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 ground (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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	42,793	2003	\$ 285,485	1
2					2
3	TOTALS	42,793		\$ 285,485	3

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR

0046276

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	92	2003	1965	\$ 2,226,786	\$ 55,670	40	\$ 55,670	\$	\$ 306,184	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10	2003 ADDITIONS		2003	10,217	1,151	VARIOUS	1,151		5,930	10
11	DOOR KICKPLATES		2004	4,897	490	10	490		2,286	11
12	NURSES STATION		2004	4,089	273	15	273		1,250	12
13	50 TON CHILLER		2004	34,400	1,720	20	1,720		7,167	13
14	UNIMAC WASHING MACHINE		2004	9,469	947	10	947		4,498	14
15	COMPUTER EQUIPMENT		2004	3,602	720	5	720		3,422	15
16	GAS DRYER		2004	4,090	409	10	409		1,943	16
17	HP LASERJET		2004	742	148	5	148		705	17
18	MECHANICAL ROOM PUMP		2004	10,766	718	15	718		3,290	18
19	ZONE VALVES FOR A/C UNITS		2004	10,025	1,002	10	1,002		4,511	19
20	USED COMPUTER EQUIPMENT/ TIME CLOCK		2004	1,760		3			1,760	20
21	BED W/ RAILS		2004	5,166	344	15	344		1,464	21
22	USED EQUIPMENT		2004	15,800		3			15,800	22
23	KITCHEN LIGHT FIXTURES		2004	984	98	10	98		418	23
24	LINEN CARTS		2004	2,734	273	10	273		1,116	24
25	PULSE OXIMETER W/ STAND		2004	1,457	208	7	208		850	25
26	TIME CLOCK		2004	1,856	186	10	186		866	26
27	VERISCO ROOFING SYSTEM		2005	29,700	2,970	10	2,970		10,643	27
28	REMODEL		2005	113,689	11,369	10	11,369		37,896	28
29	PAINTING BEDROOMS & BATHROOMS		2005	9,055	1,811	5	1,811		6,036	29
30	COMPUTERS		2005	2,000	400	5	400		1,467	30
31	PHONE SYSTEM		2005	1,196	120	10	120		439	31
32	BEDS, BEDSIDE TABLES & WARDROBES		2005	8,315	554	15	554		1,802	32
33	COMPUTER		2005	580	116	5	116		367	33
34	COMPUTER		2005	580	116	5	116		377	34
35	CARPET FRONT ENTRANCE & BACK PATIO		2006	2,795	559	5	559		1,351	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

STATE OF ILLINOIS

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR

0046276

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	DRYER	2006	\$ 3,725	\$ 372	10	\$ 372	\$	\$ 1,055	37
38	POWER LIFT	2006	1,331	133	10	133		355	38
39	GARAGE DISPOSAL	2006	1,274	255	5	255		679	39
40	ICE MACHINE	2006	3,187	319	10	319		744	40
41	COMPUTER- DIETARY	2006	5,742	108	5	108		244	41
42	SLICER	2006	704	70	10	70		158	42
43	STEAM TABLE	2006	2,094	140	15	140		302	43
44	NURSE CALL SYSTEM	2007	2,132	426	5	426		675	44
45	WANDER GUARDS	2007	7,843	784	10	784		1,307	45
46	GENERATOR	2008	6,562	1,094	5	1,094		1,094	46
47	HEATER FOR POOL	2008	2,422	242	5	242		242	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,553,766	\$ 86,315		\$ 86,315	\$	\$ 430,693	70

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

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	\$ 476,474	\$ 53,895	\$ 53,895	\$		\$ 304,739	71
72	Current Year Purchases	8,783						72
73	Fully Depreciated Assets							73
74	FINANCING COSTS	(22,906)						74
75	TOTALS	\$ 462,351	\$ 53,895	\$ 53,895	\$		\$ 304,739	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,301,602	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,210	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,210	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 735,432	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								5
6								6
7	TOTAL				\$			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: N/A *

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.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

- (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	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		hrs	\$	2,914	\$ 128,680	\$	2,914	\$ 128,680	1
2	Licensed Speech and Language Development Therapist		hrs		496	40,579		496	40,579	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		7,509	327,451		7,509	327,451	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	TOTAL			\$	10,919	\$ 496,710	\$	10,919	\$ 496,710	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR

0046276

Report Period Beginning: 1/1/08

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 11,717	\$	1
2	Cash-Patient Deposits	13,335		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	839,242		3
4	Supply Inventory (priced at)	7,009		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,742		6
7	Other Prepaid Expenses	1,424		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM ACCT	219,670		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,114,139	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	203,626		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	118,154		16
17	Accumulated Depreciation (book methods)	(124,507)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): FA ADJUSTMENT	42		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 197,315	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,311,454	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 117,148	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,006		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,763		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	13,335		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MISC. CURRENT LIAB	154,540		36
37	ESCROW HELD	(53,535)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 301,257	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	443,788		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)	\$ 443,788	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 745,045	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 566,409	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,311,454	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 429,048	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 429,048	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	137,361	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 137,361	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)	\$ 566,409	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number METROPOLIS NURSING & REHAB CTR

0046276

Report Period Beginning: 1/1/08

Ending:

Page 19

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,033,984	1
2	Discounts and Allowances for all Levels	(257,100)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,776,884	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,320,008	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,320,008	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	8,226	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	394,127	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,385	19
20	Radiology and X-Ray		20
21	Other Medical Services	83,858	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 522,596	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	490	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 490	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOME	(189)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (189)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,619,789	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	759,198	31
32	Health Care	1,956,009	32
33	General Administration	1,042,992	33
B. Capital Expense			
34	Ownership	411,999	34
C. Ancillary Expense			
35	Special Cost Centers	255,658	35
36	Provider Participation Fee	56,572	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,482,428	40
41	Income before Income Taxes (line 30 minus line 40)**	137,361	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 137,361	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 METROPOLIS NURSING & REHAB CTR

0046276

Report Period Beginning: 1/1/08

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	10,426	10,549	\$ 214,812	\$ 20.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,123	4,189	88,922	21.23	3
4	Licensed Practical Nurses	19,475	19,691	369,404	18.76	4
5	CNAs & Orderlies	52,074	52,397	498,523	9.51	5
6	CNA Trainees	3,534	3,590	36,770	10.24	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,307	4,433	42,539	9.60	10
11	Social Service Workers	5,591	5,655	88,378	15.63	11
12	Dietician	16,749	16,824	158,148	9.40	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,034	3,058	39,091	12.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,008	2,024	70,884	35.02	20
21	Assistant Administrator					21
22	Other Administrative	5,818	5,986	101,149	16.90	22
23	Office Manager					23
24	Clerical					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	1,004	1,020	10,591	10.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,143	129,416	\$ 1,719,211 *	\$ 13.28	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	184	\$ 9,565	1,3	35
36	Medical Director				36
37	Medical Records Consultant	60	2,505	9,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	9,939	11,3	44
45	Social Service Consultant	55	3,339	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	326	\$ 25,348		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

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. NO
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,416 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 56,572
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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 8,226
- (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. \$ N/A
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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A 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.