

Facility Name & ID Number City Care Center of Cobden

0041491 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	5,840	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,650	165	1,075	2,890	8
9	SNF/PED					9
10	ICF	14,822	1,445	2,065	18,332	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,472	1,610	3,140	21,222	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.57%

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 1,075

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: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	104,045	7,002	5,692	116,739		116,739		116,739		1
2	Food Purchase		116,872		116,872	(4,000)	112,872		112,872		2
3	Housekeeping	86,602	9,503	4,069	100,174		100,174		100,174		3
4	Laundry	50,520	7,656		58,176		58,176		58,176		4
5	Heat and Other Utilities			66,262	66,262		66,262		66,262		5
6	Maintenance	37,184		31,148	68,332		68,332		68,332		6
7	Other (specify):*										7
8	TOTAL General Services	278,351	141,033	107,171	526,555	(4,000)	522,555		522,555		8
	B. Health Care and Programs										
9	Medical Director			10,400	10,400		10,400		10,400		9
10	Nursing and Medical Records	581,812	99,831	1,100	682,743		682,743		682,743		10
10a	Therapy			2,769	2,769		2,769		2,769		10a
11	Activities	42,648	1,557		44,205		44,205		44,205		11
12	Social Services	24,861		4,010	28,871		28,871		28,871		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	649,321	101,388	18,279	768,988		768,988		768,988		16
	C. General Administration										
17	Administrative	55,417			55,417		55,417	26,429	81,846		17
18	Directors Fees										18
19	Professional Services			86,049	86,049		86,049	(69,576)	16,473		19
20	Dues, Fees, Subscriptions & Promotions			6,454	6,454		6,454	(3,294)	3,160		20
21	Clerical & General Office Expenses	13,769	24,436	27,923	66,128		66,128	67,168	133,296		21
22	Employee Benefits & Payroll Taxes			159,513	159,513	4,000	163,513		163,513		22
23	Inservice Training & Education										23
24	Travel and Seminar			673	673		673		673		24
25	Other Admin. Staff Transportation			451	451		451		451		25
26	Insurance-Prop.Liab.Malpractice			58,712	58,712		58,712		58,712		26
27	Other (specify):* Allocated Benefits							21,140	21,140		27
28	TOTAL General Administration	69,186	24,436	339,775	433,397	4,000	437,397	41,867	479,264		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	996,858	266,857	465,225	1,728,940		1,728,940	41,867	1,770,807		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:

01/01/09

Ending:

12/31/09

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			12,684	12,684		12,684	8,784	21,468			30
31	Amortization of Pre-Op. & Org.							29,172	29,172			31
32	Interest			13,268	13,268		13,268	161,899	175,167			32
33	Real Estate Taxes							28,324	28,324			33
34	Rent-Facility & Grounds			244,870	244,870		244,870	(237,929)	6,941			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			270,822	270,822		270,822	(9,750)	261,072			37
	Ancillary Expense											
	E. Special Cost Centers											
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			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			40,515	40,515		40,515		40,515			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	996,858	266,857	776,562	2,040,277		2,040,277	32,117	2,072,394			45

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

City Care Center of Cobden

ID# 0041491

Report Period Beginning: 01/01/09

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number City Care Center of Cobden# 0041491

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,294)	0	0	0	0	0	0	0	0	0	0	(3,294)	20
21	Clerical & General Office Expenses	(5,184)	369	0	0	0	0	0	0	0	0	0	(4,815)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(8,478)	369	0	(8,109)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,478)	369	0	(8,109)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number City Care Center of Cobden# 0041491

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(3,368)	12,152	0	0	0	0	0	0	0	0	0	8,784	30
31	Amortization of Pre-Op. & Org.	0	29,172	0	0	0	0	0	0	0	0	0	29,172	31
32	Interest	(332)	162,231	0	0	0	0	0	0	0	0	0	161,899	32
33	Real Estate Taxes	0	28,324	0	0	0	0	0	0	0	0	0	28,324	33
34	Rent-Facility & Grounds	0	(244,870)	0	0	0	0	0	0	0	0	0	(244,870)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,700)	(12,991)	0	(16,691)	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)	(12,178)	(12,622)	0	0	0	0	0	0	0	0	0	(24,800)	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
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	\$ 244,870	The Willow of Cobden,LLC	100.00%	\$	(244,870)	1
2	V	32 Interest				162,231	162,231	2
3	V	33 Real Estate Tax				28,324	28,324	3
4	V	21 Office				369	369	4
5	V	30 Depreciation				12,152	12,152	5
6	V	31 Amortization				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		\$ 244,870			\$ 232,248	\$ * (12,622)	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:

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Ending:

12/31/09

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	43,707	4.25	8.75	ABS Salary	6,293	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,429		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

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Ending: 12/31/09

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 ABS Management
 Street Address 2711 W Howard
 City / State / Zip Code chicago, Il 60645
 Phone Number (773-338-4400
 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	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		50,000	50,000	74	6,293	3
4	21	Clerical	588		380,185	380,185	74	47,846	4
5	34	Rent	588		55,149		74	6,941	5
6	27	Payroll Taxes	588		50,166		74	6,313	6
7	27	Health & Welfare	588		117,814		74	14,827	7
8	19	Professional Fees	588		3,370		74	424	8
9	21	Office	588		191,788		74	24,137	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				\$ 1,008,472	\$ 590,185		\$ 126,917	25

Facility Name & ID Number

City Care Center of Cobden

0041491

Report Period Beginning:

01/01/09

Ending:

12/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	First Bank		X	Mortgage	\$16,289.92	10/10/08	\$ 2,304,811	\$ 2,267,185	10/09/13	7.0000	\$ 162,231	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	First Bank		X			10/10/08	318,489	192,661	10/09/13	7.0000	13,268	6							
7												7							
8												8							
9	TOTAL Facility Related				\$16,289.92		\$ 2,623,300	\$ 2,459,846			\$ 175,499	9							
B. Non-Facility Related*																			
10	Interest Income										(332)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (332)	14							
15	TOTALS (line 9+line14)						\$ 2,623,300	\$ 2,459,846			\$ 175,167	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.)

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			
1. Real Estate Tax accrual used on 2008 report.		\$	<u>26,818</u>		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.)		\$	<u>27,298</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>480</u>		3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>27,844</u>		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.		\$	<u>28,324</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2004	<u>24,370</u>	8	FOR BHF USE ONLY	
	2005	<u>23,772</u>	9	13	FROM R. E. TAX STATEMENT FOR 2008 \$
	2006	<u>25,022</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2007	<u>26,292</u>	11	15	LESS REFUND FROM LINE 6 \$
	2008	<u>27,298</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
<u>Line 4:27298 x 1.02</u>					

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.

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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).

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: 12/01/95

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>1995</u>	<u>\$ 15,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 15,000	3

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	74	1995		\$ 475,200	\$ 12,152	39	\$ 12,152	\$	\$ 170,128
5									
6									
7									
8									
Improvement Type**									
9	Generator		1998	10,130	260	39	260		2,914
10	Remodeling-Addition of Dining Room & Rec Room								
11	Site Preparation		1999	60,320	1,547	39	1,547		15,792
12	Concrete, Masonery, Drywall		1999	50,469	1,294	39	1,294		13,210
13	Carpentry		1999	25,069	643	39	643		6,564
14	Electrical		1999	20,340	522	39	522		5,329
15	Heating, Ventilation & Air conditioning		1999	9,693	249	39	249		2,542
16	Plumbing		1999	11,326	290	39	290		2,960
17	Flooring		1999	2,280	58	39	58		592
18	Painting		1999	4,100	105	39	105		1,072
19	Sprinkler System		1999	13,100	336	39	336		3,430
20	Doors & Hardware		1999	8,886	228	39	228		2,327
21	Aluminum Railing		1999	11,630	298	39	298		3,042
22	Tiling		2002	11,378	292	39	292		2,263
23	Remodeling-Halls		2003	11,945	307	39	307		1,995
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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Ending:

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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	\$	\$ 234,160	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:

01/01/09

Ending:

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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	\$ 1,409	\$ 1,128	\$ (281)	10	\$ 4,512	71
72	Current Year Purchases	17,591	4,846	1,759	(3,087)	10	1,759	72
73	Fully Depreciated Assets	75,000				10	75,000	73
74								74
75	TOTALS	\$ 103,875	\$ 6,255	\$ 2,887	\$ (3,368)		\$ 81,271	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)	\$ 850,717	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,836	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,468	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,368)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 321,407	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	Allocated from ABS Management				6,941			5
6								6
7	TOTAL				\$ 6,941			7

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

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

9. Option to Buy: 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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$	\$		\$	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	TOTAL			\$		\$	\$		\$	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: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ (156,203)	\$ (146,303)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	626,347	626,347	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,712	55,712	6
7	Other Prepaid Expenses	616,089	616,089	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Others</u>	559,802	1,867,083	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,701,747	\$ 3,018,928	10
B. Long-Term Assets				
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	28,875	86,284	16
17	Accumulated Depreciation (book methods)	(77,264)	(324,178)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		437,580	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(403,378)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 202,277	\$ 537,174	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,904,024	\$ 3,556,102	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 115,054	\$ 130,054	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	192,661	192,661	29
30	Accrued Salaries Payable	35,314	35,314	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,022	4,022	31
32	Accrued Real Estate Taxes(Sch.IX-B)		28,324	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Others</u>	145,000		36
37	<u>Due to LLC</u>	111,803		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 603,854	\$ 390,375	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		2,267,185	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)	\$	\$ 2,267,185	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 603,854	\$ 2,657,560	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,300,170	\$ 898,542	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,904,024	\$ 3,556,102	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,098,843	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,098,843	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,327	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)	\$ 201,327	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,300,170	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number City Care Center of Cobden# 0041491Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 2,241,272	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,241,272	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	332	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 332	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,241,604	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	526,555	31
32	Health Care	768,988	32
33	General Administration	433,397	33
B. Capital Expense			
34	Ownership	270,822	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,040,277	40
41	Income before Income Taxes (line 30 minus line 40)**	201,327	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 201,327	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:

01/01/09

Ending:

12/31/09

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	2,040	2,120	\$ 43,731	\$ 20.63	1
2	Assistant Director of Nursing	2,064	2,272	31,126	13.70	2
3	Registered Nurses	824	850	13,893	16.34	3
4	Licensed Practical Nurses	9,434	9,971	144,973	14.54	4
5	CNAs & Orderlies	37,718	40,320	348,089	8.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,403	2,633	22,716	8.63	9
10	Activity Assistants	2,603	2,724	19,932	7.32	10
11	Social Service Workers	2,032	2,240	24,861	11.10	11
12	Dietician					12
13	Food Service Supervisor	1,995	2,183	22,631	10.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,812	10,346	81,414	7.87	15
16	Dishwashers					16
17	Maintenance Workers	5,296	5,528	37,184	6.73	17
18	Housekeepers	10,013	10,566	86,602	8.20	18
19	Laundry	6,306	6,659	50,520	7.59	19
20	Administrator	1,992	2,168	55,417	25.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,512	1,528	13,769	9.01	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)	96,044	102,108	\$ 996,858 *	\$ 9.76	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	90	\$ 5,692	1-3	35
36	Medical Director	106	10,400	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	32	2,769	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	75	4,010	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	323	\$ 23,971		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

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	
Terri Pasquino	Administrator		\$ 55,417	Workers' Compensation Insurance	\$ 62,394	IDPH License Fee	\$ 990	
				Unemployment Compensation Insurance	9,452	Advertising: Employee Recruitment	200	
				FICA Taxes	76,260	Health Care Worker Background Check	1,750	
				Employee Health Insurance	11,407	(Indicate # of checks performed <u>175</u>)		
				Employee Meals	4,000	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	3,294	
						Misc Licenses	220	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,417					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 163,513	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	(3,294)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	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
Mendel S Schneider	Accounting		\$ 8,550			\$	Out-of-State Travel	\$
Richard Peelo	Accounting		4,200					
ABS Management	Home Office-Adj out		70,000				In-State Travel	
Personnel Planners	UC Tax Consultant		1,040					
Reed Smith	Legal		816				Seminar Expense	
Abraham Gutnicki	Legal		1,443				ICLTC	673
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 86,049	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 673

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number City Care Center of Cobden

0041491

Report Period Beginning: 01/01/09

Ending: 12/31/09

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? 10
- (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. \$ 40,515
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. \$ _____
- (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: _____
- (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.