

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	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	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	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	4,072	113	4,084	8,269	8
9	SNF/PED					9
10	ICF	31,826	577		32,403	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,898	690	4,084	40,672	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.29%

D. How many bed-hold days during this year were paid by the Department?

None (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

Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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

Date started 06/01/94

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

YES Date 06/01/94 NO

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

YES NO If YES, enter number of beds certified 30 and days of care provided 3,719

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	204,375	15,116	4,034	223,525		223,525		223,525		1
2	Food Purchase		168,828		168,828		168,828	(4,611)	164,217		2
3	Housekeeping	136,873	72,074		208,947		208,947	361	209,308		3
4	Laundry	67,086	26,489		93,575		93,575		93,575		4
5	Heat and Other Utilities			123,529	123,529		123,529	1,751	125,280		5
6	Maintenance	22,220	44,837	9,978	77,035		77,035	1,385	78,420		6
7	Other (specify):*										7
8	TOTAL General Services	430,554	327,344	137,541	895,439		895,439	(1,114)	894,325		8
	B. Health Care and Programs										
9	Medical Director			4,250	4,250		4,250		4,250		9
10	Nursing and Medical Records	1,514,014	40,697	3,900	1,558,611		1,558,611	591	1,559,202		10
10a	Therapy			569,953	569,953		569,953		569,953		10a
11	Activities	62,587	6,896		69,483		69,483		69,483		11
12	Social Services	49,046			49,046		49,046		49,046		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,625,647	47,593	578,103	2,251,343		2,251,343	591	2,251,934		16
	C. General Administration										
17	Administrative	152,394		217,264	369,658		369,658	(190,206)	179,452		17
18	Directors Fees										18
19	Professional Services			65,636	65,636		65,636	13,206	78,842		19
20	Dues, Fees, Subscriptions & Promotions			6,790	6,790		6,790	(2,109)	4,681		20
21	Clerical & General Office Expenses	292,224		34,205	326,429		326,429	65,554	391,983		21
22	Employee Benefits & Payroll Taxes			337,033	337,033		337,033	3,221	340,254		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,050	2,050		2,050	(74)	1,976		24
25	Other Admin. Staff Transportation			3,299	3,299		3,299	513	3,812		25
26	Insurance-Prop.Liab.Malpractice			17,138	17,138		17,138	3,320	20,458		26
27	Other (specify):* Mgmt Alloc of Benefit							15,450	15,450		27
28	TOTAL General Administration	444,618		683,415	1,128,033		1,128,033	(91,125)	1,036,908		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,500,819	374,937	1,399,059	4,274,815		4,274,815	(91,648)	4,183,167		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			47,926	47,926		47,926	133,671	181,597			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,482	52,482		52,482	208,947	261,429			32
33	Real Estate Taxes							198,888	198,888			33
34	Rent-Facility & Grounds			600,000	600,000		600,000	(600,000)				34
35	Rent-Equipment & Vehicles			54	54		54	1,120	1,174			35
36	Other (specify):* Mortgage Insurance							18,997	18,997			36
37	TOTAL Ownership			700,462	700,462		700,462	(38,377)	662,085			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,414		114,414		114,414		114,414			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Nonallowable Cost			27,766	27,766		27,766	(27,766)				43
44	TOTAL Special Cost Centers		114,414	109,891	224,305		224,305	(27,766)	196,539			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,500,819	489,351	2,209,412	5,199,582		5,199,582	(157,791)	5,041,791			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Cahokia Nursing & Rehabilitation Center**

0039636

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(67,210)	30		9
10	Interest and Other Investment Income	(51,707)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(275)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,975)	43		18
19	Entertainment				19
20	Contributions	(1,905)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(762)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,359)	43		24
25	Fund Raising, Advertising and Promotional	(266)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(973)	43		28
29	Other-Attach Schedule <u>See Page 5A</u>	(107,488)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (235,920)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	78,129		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 78,129		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (157,791)		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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center

ID# 0039636

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Dues and Subscriptions	\$ (50)	20	1
2	Lab Expense-Med A	(10,387)	43	2
3	X-Ray Expense-Med A	(8,626)	43	3
4	Non-Allowable Dues	(2,290)	20	4
5	Management Fees	(84,782)	17	5
6	Management Fees	(3,798)	21	6
7	Real Estate Taxes	2,445	33	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	(107,488)		49

SEE ACCOUNTANTS' COMPILATION REPORT

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 Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

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	19 Professional fees	\$	Cahokia Building LLC	100.00%	\$ 4,850	\$ 4,850	1
2	V	21 Clerical & General Office-Other		Cahokia Building LLC	100.00%	533	533	2
3	V	26 Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	2,601	2,601	3
4	V	30 Depreciation		Cahokia Building LLC	100.00%	197,694	197,694	4
5	V	32 Interest income	775	Cahokia Building LLC	100.00%		(775)	5
6	V	32 Interest		Cahokia Building LLC	100.00%	259,791	259,791	6
7	V	33 Real Estate Tax		Cahokia Building LLC	100.00%	192,969	192,969	7
8	V	34 Rent	600,000	Cahokia Building LLC	100.00%		(600,000)	8
9	V	36 Mortgage Insurance		Cahokia Building LLC	100.00%	18,997	18,997	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 600,775			\$ 677,435	\$ * 76,660	14

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

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 8	\$	8	15
16	V	3 Housekeeping		SW Management Co.	100.00%	361		361	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,751		1,751	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,385		1,385	18
19	V	17 Administrative	157,264	SW Management Co.	100.00%	51,840		(105,424)	19
20	V	19 Professional Services		SW Management Co.	100.00%	9,118		9,118	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	156		156	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	68,819		68,819	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	1		1	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	513		513	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	719		719	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	15,450		15,450	26
27	V	30 Depreciation		SW Management Co.	100.00%	3,187		3,187	27
28	V	32 Interest		SW Management Co.	100.00%	1,638		1,638	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,474		3,474	29
30	V	35 Rent - Equipment & Vehicles		SW Management Co.	100.00%	1,120		1,120	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 157,264			\$ 159,540	\$ *	2,276	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 5,361	S & E Medical Supply Co.	100.00%	\$ 3,963	\$ (1,398)
16	V	3 Housekeeping	2,122	S & E Medical Supply Co.	100.00%	2,122	
17	V	10 Medical Supplies	1,209	S & E Medical Supply Co.	100.00%	1,800	591
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 8,692			\$ 7,885	\$ * (807)

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.00	Salary	\$ 11,745	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	3.5	9.00	Salary&Fees	15,313	L17,C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	4.2	10.00	Salary	16,443	L21,C7	3
4											4
5											5
6											6
7			Note : All individuals work in excess of 40 hours per week.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,501		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 SW Management Co.
 Street Address 7434 N. Skokie Blvd.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

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	2	Food	Bed Days Available	608,840	11	\$ 89	\$ 54,750	\$ 8	1	
2	3	Housekeeping	Bed Days Available	608,840	11	4,018	54,750	361	2	
3	5	Heat and Other Utilities	Bed Days Available	608,840	11	19,472	54,750	1,751	3	
4	6	Maintenance	Bed Days Available	608,840	11	15,398	54,750	1,385	4	
5	19	Professional Services	Bed Days Available	608,840	11	101,398	54,750	9,118	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	608,840	11	1,732	54,750	156	6	
7	21	Clerical & General Office Exp	Bed Days Available	608,840	11	765,293	711,669	68,819	7	
8	24	Travel and Seminar	Bed Days Available	608,840	11	15	54,750	1	8	
9	25	Other Admin. Staff Transport	Bed Days Available	608,840	11	5,704	54,750	513	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	608,840	11	8,000	54,750	719	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	608,840	11	171,812	54,750	15,450	11	
12	32	Interest	Bed Days Available	608,840	11	18,211	54,750	1,638	12	
13	33	Real Estate Taxes	Bed Days Available	608,840	11	38,636	54,750	3,474	13	
14	35	Rent - Equipment & Vehicles	Bed Days Available	608,840	11	12,454	54,750	1,120	14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	43	11	743,036	743,036	3	51,840	17
18									18	
19									19	
20	30	Depreciation	Direct Cost						3,187	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,905,268	\$ 1,454,705	\$ 159,540	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization S & E Medical Supply Co.
 Street Address 3100 Commercial Avenue
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 982-9300
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 3,963	1
2	3	Housekeeping	Direct Cost					2,122	2
3	10	Medical Supplies	Direct Cost					1,800	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 7,885	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Heartland Bank-HUD		X	Mortgage	\$23,524.00	11/27/01	\$ 3,961,000	\$ 3,780,527	12/01/36	0.0635	\$ 241,265	1								
2	CCC Note Holders Assoc.		X	Second Mortgage	Varies	11/27/01	265,000	265,000	12/01/36	0.0500	14,214	2								
3							Amortization of Mortgage Costs				4,312	3								
4												4								
5												5								
Working Capital																				
6	N/P Stockholders	X		Working Capital				978,740			52,482	6								
7		X		Working Capital								7								
8												8								
9	TOTAL Facility Related				\$23,524.00		\$ 4,226,000	\$ 5,024,267			\$ 312,273	9								
B. Non-Facility Related*																				
10							Allocation from Management Company				1,638	10								
11							Related party interest expense net of interest income				(37,388)	11								
12							Interest income offset				(14,319)	12								
13							Interest income offset from real estate entity				(775)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (50,844)	14								
15	TOTALS (line 9+line14)						\$ 4,226,000	\$ 5,024,267			\$ 261,429	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,997 Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cahokia Nursing & Rehabilitation Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039636

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 932-2304

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>06-02.0-310-055</u>	<u>Long term care property</u>	\$ <u>174,706.68</u>	\$ <u>174,706.68</u>
2. <u>06-02.0-310-054</u>	<u>Long term care property</u>	\$ <u>2,707.64</u>	\$ <u>2,707.64</u>
3. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>39,720.37</u>	\$ <u>3,474.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>217,134.69</u>	\$ <u>180,888.32</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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).

None

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

1. Total Amount Incurred: _____ 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	<u>Resident Care</u>		<u>2001</u>	<u>\$ 230,000</u>	<u>1</u>
2	<u>Office Space for Employees</u>		<u>2006</u>	<u>15,000</u>	<u>2</u>
3	TOTALS			\$ 245,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	150	2001		\$ 2,928,441	\$	15-40	\$ 80,744	\$ 80,744	\$ 412,355	4
5		2006		55,818		40	716	716	716	5
6										6
7	Allocated from Mangement Company	1995		39,396		39	1,126	1,126	13,119	7
8										8
	Improvement Type**									
9	Various		1994	17,857	268	20	523	255	13,850	9
10	Various		1995	33,623	337	20	1,681	1,344	19,730	10
11	Various		1996	2,178	56	20	109	53	1,163	11
12	Various		1997	9,423		20	471	471	4,478	12
13	Various		1998	4,800	123	20	240	117	2,040	13
14	Various		1999	16,266	93	20	813	720	6,285	14
15	Air Handler		2000	1,516		5			1,516	15
16	Alarm System		2001	1,908		5			1,908	16
17	Blind		2001	1,212		5			1,212	17
18	Air Handler		2001	1,317		20	66	66	363	18
19	Fan Motor		2001	1,123		20	56	56	285	19
20	Drywall-Dining Room		2002	10,650	184	10	1,065	881	5,148	20
21	Door		2002	9,860	184	20	493	309	2,013	21
22	Air Conditioner		2002	1,198		7	171	171	785	22
23	Air Conditioner		2002	1,582		7	226	226	1,036	23
24	Air Conditioners		2002	4,284		7	612	612	2,754	24
25	Compressor Air Maxi		2002	1,269		7	181	181	846	25
26	Roof - New		2003	97,996	2,513	20	4,900	2,387	18,374	26
27	Nursing Station		2003	35,060		20	1,753	1,753	5,843	27
28	Nursing Station		2003	28,692		20	1,435	1,435	5,978	28
29	Nursing Station		2003	6,368		20	318	318	982	29
30	Replace Accelerator		2003	968		20	48	48	193	30
31	Sprinkler System		2004	3,610	131	20	181	50	451	31
32	Smoke shelter		2004	6,041	220	20	302	82	755	32
33	Security System		2005	11,166	406	20	558	152	838	33
34	Condensing Unit - 5 Ton		2005	1,959	71	20	98	27	147	34
35	Cabinets and countertops		2005	110,923	4,011	20	5,546	1,535	8,319	35
36	Air Handler		2005	1,549	56	20	78	22	116	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	Asphalt Parking Lot	2005	\$ 5,570	\$ 529	20	\$ 279	\$ (250)	\$ 418	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	82	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	315	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	329	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	110	41
42	Door Alarms	2005	3,587	130	20	180	50	269	42
43	Wallpaper	2005	17,835		20	892	892	1,338	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	2,220	44
45	6 Doors	2005	1,926	70	20	96	26	145	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	780	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	366	47
48	Duct Heater	2006	1,195	42	20	30	(12)	30	48
49	Kitchen Garbage Disposal	2006	1,467	1,467	20	37	(1,430)	37	49
50	Copper Pipe & Concrete	2006	3,722	118	20	93	(25)	93	50
51	Fence	2006	6,061	303	20	151	(152)	151	51
52	Shower Remodel - Hall 400	2006	21,570	164	20	539	375	539	52
53	Tile Kitchen Floor	2006	9,750	74	20	244	170	244	53
54	Shower Remodel - Hall 200	2006	21,570	98	20	539	441	539	54
55	Shower Remodel - Hall 500	2006	21,570	33	20	539	506	539	55
56	Sprinkler System - new pipe	2006	19,579	208	20	490	282	490	56
57	Front Entrance	2006	2,150	3	20	54	51	54	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	76	20	84	8	84	58
59	3 Ton Condensing Unit	2006	1,729	39	20	43	4	43	59
60	Compressor-Walk In Freezer	2006	1,784	51	20	44	(7)	44	60
61	Air Conditioners (5)	2006	2,146	2,146	10	107	(2,039)	107	61
62	Air Conditioners (6)	2006	2,576	2,575	20	64	(2,511)	64	62
63	Phone System	2006	1,658	1,657	20	41	(1,616)	41	63
64	Allocated from SW Management - Leasehold Improvements	1995	4,203		20	210	210	2,746	64
65	Allocated from SW Management - Leasehold Improvements	1996	734		20	37	37	388	65
66	Allocated from SW Management - Leasehold Improvements	1997	1,057		20	53	53	633	66
67	Allocated from SW Management - Leasehold Improvements	1998	728		20	36	36	318	67
68	Allocated from SW Management - Leasehold Improvements	1999	2,021		20	101	101	716	68
69	Allocated from SW Management - Leasehold Improvements	2005	4,180		20	209	209	314	69
70	TOTAL (lines 4 thru 69)		\$ 3,667,797	\$ 19,237		\$ 112,504	\$ 93,267	\$ 548,184	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 518,475	\$ 8,727	\$ 66,681	\$ 57,954	10	\$ 381,408	71
72	Current Year Purchases	19,964	19,962	997	(18,965)	10	998	72
73	Fully Depreciated Assets	317,506					228,261	73
74	Allocation from Management Company	10,634		360	360	10	10,066	74
75	TOTALS	\$ 866,579	\$ 28,689	\$ 68,038	\$ 39,349		\$ 620,733	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	Allocation from Management Company		2004	\$ 5,276	\$	\$ 1,055	\$ 1,055	5	\$ 2,638	76
77										77
78										78
79										79
80	TOTALS			\$ 5,276	\$	\$ 1,055	\$ 1,055		\$ 2,638	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)	\$ 4,784,652	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,926	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,597	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 133,671	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,171,555	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 54 Description: Miscellaneous Rental Expense : \$54

(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	<u>SW Management Allocation</u>		\$	\$ <u>1,120</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,120</u>	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</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		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	L10A, C3	hrs	\$	14,483	\$ 201,604	\$	14,483	\$ 201,604	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		9,002	125,311		9,002	125,311	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		16,976	236,474		16,976	236,474	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				114,414		114,414	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	40,461	\$ 563,389	\$ 114,414	40,461	\$ 677,803	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 1,000	\$ 1,000	1
2	Cash-Patient Deposits	22,610	22,610	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,436,847	1,436,847	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,667	10,115	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	272,087	528,131	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,737,211	\$ 1,998,703	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	2,842,869	14
15	Leasehold Improvements, at Historical Cost	494,190	824,928	15
16	Equipment, at Historical Cost	373,072	871,855	16
17	Accumulated Depreciation (book methods)	(459,769)	(1,171,555)	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): _____		129,564	22
23	Other(specify): <u>See Schedule 17A</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 478,311	\$ 3,742,661	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,215,522	\$ 5,741,364	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 217,381	\$ 67,856	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,736	28,736	28
29	Short-Term Notes Payable	978,740	978,740	29
30	Accrued Salaries Payable	131,127	131,127	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,674	17,674	31
32	Accrued Real Estate Taxes(Sch.IX-B)		183,000	32
33	Accrued Interest Payable	5,027	34,205	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	484,569	90,664	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,863,254	\$ 1,532,002	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		4,045,527	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)	\$	\$ 4,045,527	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,863,254	\$ 5,577,529	46
47	TOTAL EQUITY(page 18, line 24)	\$ 352,268	\$ 163,835	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,215,522	\$ 5,741,364	48

Cahokia Nursing & Rehabilitation Center, Inc.

Provider #: 0039636

12/31/2006

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve	-	173,923
RE Escrow Real Estate Tax	-	82,121
Reimbursement Due	(130)	(130)
Short Term Loan Exchange	275,606	275,606
Due to Public Aid	(3,389)	(3,389)
Total Line 9-Other Current Assets (Specify)	272,087	528,131

Other Long-Term Assets (Specify)

RE Mortgage Costs	-	150,935
RE Accumulated Amortization	-	(21,371)
Total Line 22-Other Long-Term Assets (specify)	-	129,564

Other Current Liabilities (Specify)

Insurance Premiums Payable	1,271	1,271
Accrued Expenses	75,221	75,221
Due/From Cahokia Property	393,904	(1)
Due/From Vacant Cahokia Property	14,173	14,173
Total Line 36-Other Current Liabilities (Specify)	484,569	90,664

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 219,399	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 219,399	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,869	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)	\$ 132,869	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)	\$ 352,268	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,773,525	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,773,525	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	523,790	6
7	Oxygen	18,957	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 542,747	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***	14,319	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,319	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,860	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,860	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,332,451	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	895,439	31
32	Health Care	2,251,343	32
33	General Administration	1,128,033	33
	B. Capital Expense		
34	Ownership	700,462	34
	C. Ancillary Expense		
35	Special Cost Centers	142,180	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,199,582	40
41	Income before Income Taxes (line 30 minus line 40)**	132,869	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 132,869	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,880	2,000	\$ 59,452	\$ 29.73	1
2	Assistant Director of Nursing	1,976	2,080	56,886	27.35	2
3	Registered Nurses	3,376	3,552	85,073	23.95	3
4	Licensed Practical Nurses	23,275	24,862	484,615	19.49	4
5	CNAs & Orderlies	78,265	82,406	759,174	9.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,303	5,903	68,814	11.66	8
9	Activity Director					9
10	Activity Assistants	5,761	6,302	62,587	9.93	10
11	Social Service Workers	3,565	3,862	49,046	12.70	11
12	Dietician					12
13	Food Service Supervisor	1,646	1,946	26,765	13.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,945	20,383	177,610	8.71	15
16	Dishwashers					16
17	Maintenance Workers	1,708	1,890	22,220	11.76	17
18	Housekeepers	17,743	18,782	136,873	7.29	18
19	Laundry	9,041	9,547	67,086	7.03	19
20	Administrator	2,360	2,640	152,394	57.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,023	16,092	292,224	18.16	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)	189,867	202,247	\$ 2,500,819 *	\$ 12.37	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	Monthly	\$ 4,034	L1, C3	35
36	Medical Director	Monthly	4,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,900	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	486	6,564	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	486	\$ 18,748		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Robin Suydam</u>	<u>Administrator</u>	<u>0%</u>	\$ <u>129,897</u>	<u>Workers' Compensation Insurance</u>	\$ <u>54,216</u>	<u>IDPH License Fee</u>	\$ <u>995</u>	
<u>Teresa Ruberg</u>	<u>Administrator</u>	<u>0%</u>	<u>22,497</u>	<u>Unemployment Compensation Insurance</u>	<u>61,874</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>189,040</u>	<u>Health Care Worker Background Check</u>	<u>1,855</u>	
				<u>Employee Health Insurance</u>	<u>28,910</u>	(Indicate # of checks performed <u>155</u>)		
				<u>Employee Meals</u>	<u>3,221</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Council on Long Term Care</u>	<u>3,375</u>	
				<u>Tuition Reimbursement</u>	<u>345</u>	<u>Miscellaneous Dues & Permits</u>	<u>280</u>	
				<u>Miscellaneous Employee Benefits</u>	<u>2,648</u>	<u>Miscellaneous Inspections & Licenses</u>	<u>310</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>152,394</u>			<u>Allocation from Management Company</u>	<u>156</u>	
(List each licensed administrator separately.)						<u>Less: Nonallowable Dues</u>	<u>(2,290)</u>	
B. Administrative - Other						<u>Less: Public Relations Expense</u>	()	
Description			Amount			<u>Non-allowable advertising</u>	()	
<u>SW Management-Home Office & Management Fee</u>			\$ <u>157,264</u>			<u>Yellow page advertising</u>	()	
<u>Ronnie Klein-Management Fees</u>			<u>60,000</u>					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>340,254</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>4,681</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>217,264</u>	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services				<u>N/A</u>			<u>Out-of-State Travel</u>	\$
Vendor/Payee	Type		Amount					
<u>Tueth, Kenney, Cooper, Mohan</u>	<u>Legal</u>		\$ <u>35,143</u>					
<u>Ashman & Stein</u>	<u>Legal</u>		<u>1,567</u>					
<u>Amelung, Wulff & Willenbrock</u>	<u>Legal</u>		<u>150</u>					
<u>Burroughs, Helper, Broom</u>	<u>Legal</u>		<u>9,226</u>			<u>In-State Travel</u>		
<u>Personnel Planners, Inc.</u>	<u>Unemployment Consultant</u>		<u>2,334</u>					
<u>RSM McGladrey</u>	<u>Accounting</u>		<u>17,216</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>65,636</u>	TOTAL			<u>Seminar Expense</u>	<u>1,975</u>
(If total legal fees exceed \$5,000, attach copy of invoices.)							<u>Allocation from Management Co</u>	<u>1</u>
							<u>Entertainment Expense</u>	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ <u>1,976</u>

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Cahokia Nursing & Rehabilitation Center

Provider # : 0039636

12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	65,636
Allocated from Real Estate Entity - Accounting	4,850
Allocated from Mangement Company - Legal	7,512
Allocated from Mangement Company - Accounting	1,606
Less : Non-Allowable Legal Costs	(762)
Total (Agree to Schedule V, Line 19, Column 8)	<u>78,842</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2003					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/06

Ending: 12/31/06

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on LTC : \$1085
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 276 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
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. \$ 3,221 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? None
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
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. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT