



Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

# 0039636 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	5,037	95	4,826	9,958	8
9	SNF/PED					9
10	ICF	30,343	1,836	338	32,517	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,380	1,931	5,164	42,475	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.58%

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  Note: 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 06/01/1994

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/01/1994 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 3,150

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	210,552	19,345	4,360	234,257		234,257		234,257		1
2	Food Purchase		190,867		190,867		190,867	(4,692)	186,175		2
3	Housekeeping	141,312	85,916		227,228		227,228	163	227,391		3
4	Laundry	76,638	28,526		105,164		105,164		105,164		4
5	Heat and Other Utilities			169,414	169,414		169,414	1,501	170,915		5
6	Maintenance	23,709	53,867	12,636	90,212		90,212	1,933	92,145		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	452,211	378,521	186,410	1,017,142		1,017,142	(1,095)	1,016,047		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,696,710	53,388	6,994	1,757,092		1,757,092	(116)	1,756,976		10
10a	Therapy			472,971	472,971		472,971		472,971		10a
11	Activities	66,583	6,818		73,401		73,401		73,401		11
12	Social Services	45,051			45,051		45,051		45,051		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,808,344	60,206	482,965	2,351,515		2,351,515	(116)	2,351,399		16
	<b>C. General Administration</b>										
17	Administrative	204,497		127,678	332,175		332,175	(84,254)	247,921		17
18	Directors Fees										18
19	Professional Services			49,553	49,553		49,553	15,151	64,704		19
20	Dues, Fees, Subscriptions & Promotions			16,155	16,155		16,155	(594)	15,561		20
21	Clerical & General Office Expenses	375,367		41,617	416,984		416,984	36,086	453,070		21
22	Employee Benefits & Payroll Taxes			351,616	351,616		351,616	3,767	355,383		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,505	1,505		1,505	(397)	1,108		24
25	Other Admin. Staff Transportation			3,077	3,077		3,077	671	3,748		25
26	Insurance-Prop.Liab.Malpractice			17,372	17,372		17,372	3,536	20,908		26
27	Other (specify):*							12,545	12,545		27
28	<b>TOTAL General Administration</b>	579,864		608,573	1,188,437		1,188,437	(13,489)	1,174,948		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,840,419	438,727	1,277,948	4,557,094		4,557,094	(14,700)	4,542,394		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			58,751	58,751		58,751	96,024	154,775			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,311	50,311		50,311	207,752	258,063			32
33	Real Estate Taxes							192,149	192,149			33
34	Rent-Facility & Grounds			600,000	600,000		600,000	(600,000)				34
35	Rent-Equipment & Vehicles							1,057	1,057			35
36	Other (specify):* <b>Mortgage Insurance</b>							18,786	18,786			36
37	<b>TOTAL Ownership</b>			709,062	709,062		709,062	(84,232)	624,830			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,331		101,331		101,331		101,331			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):* <b>Non-allowable Cos</b>			17,110	17,110		17,110	(17,110)				43
44	<b>TOTAL Special Cost Centers</b>		101,331	99,235	200,566		200,566	(17,110)	183,456			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,840,419	540,058	2,086,245	5,466,722		5,466,722	(116,042)	5,350,680			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:

01/01/2007

Ending:

12/31/2007

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,799	30		9
10	Interest and Other Investment Income	(45,147)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(280)	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	(29)	43		18
19	Entertainment				19
20	Contributions	(1,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(365)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,277)	43		28
29	Other-Attach Schedule See Pg. 5A	(11,987)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (55,786)		\$	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(60,256)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (60,256)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (116,042)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center

ID# 0039636

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Education and Seminar	\$ (450)	24	1
2	Lab Expense-Med A	(7,942)	43	2
3	X-Ray Expense-Med A	(5,717)	43	3
4	Association Fees	(666)	20	4
5	Real Estate Taxes	2,788	33	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(11,987)		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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Services	\$	Cahokia Building LLC	100.00%	\$ 6,000	\$ 6,000	1
2	V	21 Clerical & General Office-Other		Cahokia Building LLC	100.00%	229	229	2
3	V	26 Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	2,905	2,905	3
4	V	30 Depreciation		Cahokia Building LLC	100.00%	88,468	88,468	4
5	V	32 Interest Income	5,164	Cahokia Building LLC	100.00%		(5,164)	5
6	V	32 Interest		Cahokia Building LLC	100.00%	256,604	256,604	6
7	V	33 Real Estate Tax		Cahokia Building LLC	100.00%	185,854	185,854	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%	18,786	18,786	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 605,164			\$ 558,846	\$ * (46,318)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 27	\$	27	15
16	V	3 Housekeeping		SW Management Co.	100.00%	163		163	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,501		1,501	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,933		1,933	18
19	V	17 Administrative	127,678	SW Management Co.	100.00%	43,424		(84,254)	19
20	V	19 Professional Services		SW Management Co.	100.00%	9,151		9,151	20
21	V	20 Dues,Fees,Subs & Promotions		SW Management Co.	100.00%	72		72	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	35,857		35,857	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	53		53	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	671		671	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	631		631	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,545		12,545	26
27	V	30 Depreciation		SW Management Co.	100.00%	2,757		2,757	27
28	V	32 Interest		SW Management Co.	100.00%	1,459		1,459	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,507		3,507	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,057		1,057	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		\$ 127,678			\$ 114,808	\$ *	(12,870)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 7,154	S & E Medical Supply Co.	100.00%	\$ 6,202	\$ (952)
16	V	3 Housekeeping	68,466	S & E Medical Supply Co.	100.00%	68,466	
17	V	10 Medical Supplies	2,511	S & E Medical Supply Co.	100.00%	2,395	(116)
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		\$ 78,131			\$ 77,063	\$ * (1,068)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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	\$ 13,519	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	5	9.00	Salary&Fees	16,386	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	10.00	Salary	13,519	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9		All individuals work in excess of 40 hours per week.									9
10											10
11											11
12											12
13								TOTAL	\$ 43,424		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:

01/01/2007

Ending: 2/31/2007

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	645,320	11	\$ 319	\$ 54,750	\$ 27	1	
2	3	Housekeeping	Bed Days Available	645,320	11	1,918	54,750	163	2	
3	5	Heat and Other Utilities	Bed Days Available	645,320	11	17,688	54,750	1,501	3	
4	6	Maintenance	Bed Days Available	645,320	11	22,780	54,750	1,933	4	
5	19	Professional Services	Bed Days Available	645,320	11	107,864	54,750	9,151	5	
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	645,320	11	844	54,750	72	6	
7	21	Clerical & General Office Exp	Bed Days Available	645,320	11	422,637	373,471	54,750	35,857	7
8	24	Travel and Seminar	Bed Days Available	645,320	11	625	54,750	53	8	
9	25	Other Admin. Staff Transport	Bed Days Available	645,320	11	7,906	54,750	671	9	
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	645,320	11	7,442	54,750	631	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	645,320	11	147,860	54,750	12,545	11	
12	32	Interest	Bed Days Available	645,320	11	17,198	54,750	1,459	12	
13	33	Real Estate Taxes	Bed Days Available	645,320	11	41,339	54,750	3,507	13	
14	35	Rent-Equipment & Vehicles	Bed Days Available	645,320	11	12,453	54,750	1,057	14	
15									15	
16									16	
17	17	Administrative	Avg Hours Worked	40	11	360,500	360,500	3	27,038	17
18		Administrative	Avg Hours Worked	55	7	180,250	180,250	5	16,386	18
19									19	
20	30	Depreciation	Direct Cost			32,495			2,757	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,118	\$ 914,221	\$ 114,808	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

# 0039636

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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		\$	\$		\$ 6,202	1
2	3	Housekeeping	Direct Cost					68,466	2
3	10	Medical Supplies	Direct Cost					2,395	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				\$	\$		\$ 77,063	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

# 0039636

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Heartland Bank-HUD		X	Mortgage	\$23,524.00	11/27/01	\$ 3,961,000	\$ 3,737,055	12/01/36	0.0635	\$ 238,583	1								
2	CCC Note Holders Assoc.		X	Second Mortgage	Varies	11/27/01	265,000	265,000	12/01/36	0.0500	13,709	2								
3							Amortization of Mortgage Costs				4,312	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	N/P Stockholders	X		Working Capital				525,000			50,311	6								
7		X		Working Capital								7								
8												8								
9	<b>TOTAL Facility Related</b>				\$23,524.00		\$ 4,226,000	\$ 4,527,055			\$ 306,915	9								
<b>B. Non-Facility Related*</b>																				
10							Allocation from Management Company				1,459	10								
11							Related Party Interest Expense net of Interest Income				(16,750)	11								
12							Interest Income Offset				(28,397)	12								
13							Interest Income Offset from Real Estate Entity				(5,164)	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (48,852)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 4,226,000	\$ 4,527,055			\$ 258,063	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,786 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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>183,000</b>	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.)	2006	\$	<b>182,642</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(358)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>189,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>3,507</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>192,149</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	<b>125,340</b>	8	
	2003	<b>143,835</b>	9	
	2004	<b>160,219</b>	10	
	2005	<b>177,414</b>	11	
	2006	<b>179,854</b>	12	
<b>2007 RE Tax Accrual = 182,642 X 1.03 = 188,121. Use 189,000.</b>				
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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) 982-2304

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>179,854.44</u>	\$ <u>179,854.44</u>
2. <u>06-02.0-310-054</u>	<u>Long term care property</u>	\$ <u>2,787.46</u>	\$ <u>2,787.46</u>
3. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>42,503.98</u>	\$ <u>3,507.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>225,145.88</u>	\$ <u>186,148.90</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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	<b>TOTALS</b>			<b>\$ 245,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Cahokia Nursing &amp; Rehabilitation Center

# 0039636

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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		\$ 2,928,442	\$	15-40	\$ 80,744	\$ 80,744	\$ 493,099	4
5		2006		55,818	2,030	40	1,431	(599)	2,147	5
6										6
7	Allocated from Management Co.	1995		36,722		39	1,049	1,049	13,278	7
8										8
<b>Improvement Type**</b>										
9	Various		1994	17,857	268	20	523	255	14,372	9
10	Various		1995	33,623	337	20	1,681	1,344	21,412	10
11	Various		1996	2,178	56	20	109	53	1,272	11
12	Various		1997	9,423		20	471	471	4,950	12
13	Various		1998	4,800	123	20	240	117	2,280	13
14	Various		1999	16,266	93	20	813	720	7,098	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	428	18
19	Fan Motor		2001	1,123		20	56	56	341	19
20	Drywall-Dining Room		2002	10,650	184	10	1,065	881	6,213	20
21	Door		2002	9,860	184	20	493	309	2,506	21
22	Air Conditioner		2002	1,198		7	171	171	956	22
23	Air Conditioner		2002	1,582		7	226	226	1,262	23
24	Air Conditioners		2002	4,284		7	612	612	3,366	24
25	Compressor Air Maxi		2002	1,269		7	181	181	1,027	25
26	Roof - New		2003	97,996	2,513	20	4,900	2,387	23,274	26
27	Nursing Station		2003	35,060		20	1,753	1,753	7,596	27
28	Nursing Station		2003	28,692		20	1,435	1,435	7,412	28
29	Nursing Station		2003	6,368		20	318	318	1,301	29
30	Replace Accelerator		2003	968		20	48	48	242	30
31	Sprinkler System		2004	3,610	131	20	181	50	632	31
32	Smoke shelter		2004	6,041	220	20	302	82	1,057	32
33	Security System		2005	11,166	406	20	558	152	1,396	33
34	Condensing Unit - 5 Ton		2005	1,959	71	20	98	27	245	34
35	Cabinets and countertops		2005	110,923	4,011	20	5,546	1,535	13,865	35
36	Air Handler		2005	1,549	56	20	78	22	194	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 &amp; ID Number Cahokia Nursing &amp; Rehabilitation Center

# 0039636

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$ 476	20	\$ 279	\$ (198)	\$ 696	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	137	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	525	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	549	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	183	41
42	Door Alarms	2005	3,587	130	20	179	49	448	42
43	Wallpaper	2005	17,835		20	892	892	2,229	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	3,700	44
45	6 Doors	2005	1,926	70	20	96	26	241	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	1,299	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	610	47
48	Duct Heater	2006	1,195	43	20	60	17	90	48
49	Kitchen Garbage Disposal	2006	1,467	469	20	73	(396)	110	49
50	Copper Pipe & Concrete	2006	3,722	135	20	186	51	279	50
51	Fence	2006	6,061	576	20	303	(273)	455	51
52	Shower Remodel - Hall 400	2006	21,570	784	20	1,079	295	1,618	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	731	53
54	Shower Remodel - Hall 200	2006	21,570	784	20	1,079	295	1,618	54
55	Shower Remodel - Hall 500	2006	21,570	784	20	1,079	295	1,618	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	1,468	56
57	Front Entrance	2006	2,150	78	20	108	30	161	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	252	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	130	59
60	Compressor-Walk In Freezer	2006	1,784	65	20	89	24	134	60
61	Air Conditioners (5)	2006	2,146	687	10	215	(472)	322	61
62	Air Conditioners (6)	2006	2,576	824	20	129	(695)	193	62
63	Phone System	2006	1,658	530	20	83	(447)	124	63
64	Remove & reinstall 6 dry pendants	2007	3,039	97	20	76	(21)	76	64
65	2 Hot Water Heaters	2007	7,500	216	20	188	(29)	188	65
66	2 Mixing valves for hot water heaters	2007	3,160	77	20	79	2	79	66
67	New Window Glass	2007	3,562	92	20	89	(3)	89	67
68	Paving, Parking Lot & Driveway	2007	32,275	1,615	20	807	(808)	807	68
69	Handrails	2007	2,980	2,980	20	75	(2,906)	75	69
70	TOTAL (lines 4 thru 69)		\$ 3,704,717	\$ 24,248		\$ 116,909	\$ 92,661	\$ 659,088	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12A, Carried Forward		\$ 3,704,717	\$ 24,248		\$ 116,909	\$ 92,661	\$ 659,088	1
2	Fire Damper and Roof Vent	2007	5,114	84	20	128	44	128	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790	8,790	20	220	(8,570)	220	3
4									4
5									5
6									6
7									7
8									8
9	Allocated from SW Management - Leasehold Improvements	1995	3,918		20	196	196	2,755	9
10	Allocated from SW Management - Leasehold Improvements	1996	684		20	34	34	396	10
11	Allocated from SW Management - Leasehold Improvements	1997	985		20	49	49	639	11
12	Allocated from SW Management - Leasehold Improvements	1998	678		20	34	34	331	12
13	Allocated from SW Management - Leasehold Improvements	1999	1,883		20	94	94	761	13
14	Allocated from SW Management - Leasehold Improvements	2005	3,896		20	195	195	487	14
15	Allocated from SW Management - Leasehold Improvements	2007	2,206		20	55	55	55	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	TOTAL (lines 1 thru 33)		\$ 3,732,871	\$ 33,122		\$ 117,914	\$ 84,792	\$ 664,860	34

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	\$ 752,801	\$ 12,973	\$ 35,122	\$ 22,149	10	\$ 542,646	71
72	Current Year Purchases	14,933	12,656	689	(11,967)	10	689	72
73	Fully Depreciated Assets	103,144					103,144	73
74	Allocation from Management Co	9,907		67	67	10	8,344	74
75	TOTALS	\$ 880,785	\$ 25,629	\$ 35,878	\$ 10,249		\$ 654,823	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	2004 Cadillac	2004	\$ 4,915	\$	\$ 983	\$ 983	5	\$ 3,441	76
77										77
78										78
79										79
80	TOTALS			\$ 4,915	\$	\$ 983	\$ 983		\$ 3,441	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)	\$ 4,863,571	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,751	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 154,775	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 96,024	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,323,124	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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: \$ \_\_\_\_\_ 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	SW Management Allocation		\$ _____	\$ 1,057	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 1,057	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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	6,301	\$ 176,435	\$	6,301	\$ 176,435	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,461	87,817		1,461	87,817	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		7,844	204,016		7,844	204,016	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				101,331		101,331	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	<b>TOTAL</b>			\$	15,606	\$ 468,268	\$ 101,331	15,606	\$ 569,599	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,000	\$ 1,000	1
2	Cash-Patient Deposits	39,662	39,662	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,000 )	1,013,259	1,013,259	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,791	28,890	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	292,774	492,388	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,351,486	\$ 1,575,199	10
<b>B. Long-Term Assets</b>				
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	2,840,195	14
15	Leasehold Improvements, at Historical Cost	562,926	892,676	15
16	Equipment, at Historical Cost	385,689	885,700	16
17	Accumulated Depreciation (book methods)	(496,578)	(1,323,124)	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 (spec See Sched 17A		125,252	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 522,855	\$ 3,665,699	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,874,341	\$ 5,240,898	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 124,059	\$ (94,517)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,893	43,893	28
29	Short-Term Notes Payable	525,000	525,000	29
30	Accrued Salaries Payable	154,924	154,924	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,617	19,617	31
32	Accrued Real Estate Taxes(Sch.IX-B)		189,000	32
33	Accrued Interest Payable		42,657	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Schedule 17A	563,380	82,936	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,430,873	\$ 963,510	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		4,002,055	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,002,055	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,430,873	\$ 4,965,565	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 443,468	\$ 275,333	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,874,341	\$ 5,240,898	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Cahokia Nursing & Rehabilitation Center, Inc.  
Provider #: 0039636  
12/31/2007

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Escrow-Insurance	-	13,243
RE Escrow-MIP	-	225
RE Replacement Reserve	-	126,194
RE Escrow Real Estate Tax	-	59,952
Employee Payroll Advance	338	338
Short Term Loan Exchange	292,436	292,436
<b>Total Line 9-Other Current Assets (Specify)</b>	<b>292,774</b>	<b>492,388</b>

Other Long-Term Assets (Specify)

RE Capitalized Costs	-	150,935
RE Accumulated Amortization	-	(25,683)
<b>Total Line 22-Other Long-Term Assets (specify)</b>	<b>-</b>	<b>125,252</b>

Other Current Liabilities (Specify)

Acc. Retirement (From P/R)	750	750
Accrued Expenses	122,257	122,257
Due to Public Aid	276	276
Due/From Cahokia Property	425,924	(54,520)
Due/From Vacant Cahokia Property	14,173	14,173
<b>Total Line 36-Other Current Liabilities (Specify)</b>	<b>563,380</b>	<b>82,936</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>352,268</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>21,943</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>374,211</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>69,257</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>69,257</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>443,468</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,008,889	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,008,889	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	482,573	6
7	Oxygen	16,120	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 498,693	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	28,397	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 28,397	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,535,979	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,017,142	31
32	Health Care	2,351,515	32
33	General Administration	1,188,437	33
	<b>B. Capital Expense</b>		
34	Ownership	709,062	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	118,441	35
36	Provider Participation Fee	82,125	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,466,722	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	69,257	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 69,257	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: 01/01/2007

Ending: 12/31/2007

**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	1,944	2,080	\$ 60,678	\$ 29.17	1
2	Assistant Director of Nursing	1,908	2,036	53,381	26.22	2
3	Registered Nurses	3,644	3,811	95,590	25.08	3
4	Licensed Practical Nurses	23,083	24,716	487,055	19.71	4
5	CNAs & Orderlies	86,464	91,404	910,935	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,751	7,434	89,071	11.98	8
9	Activity Director					9
10	Activity Assistants	6,274	6,641	66,583	10.03	10
11	Social Service Workers	3,406	3,678	45,051	12.25	11
12	Dietician					12
13	Food Service Supervisor	1,767	1,954	27,864	14.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,411	20,748	182,688	8.81	15
16	Dishwashers					16
17	Maintenance Workers	2,027	2,095	23,709	11.32	17
18	Housekeepers	17,244	18,245	141,312	7.75	18
19	Laundry	9,933	10,403	76,638	7.37	19
20	Administrator	4,008	4,160	204,497	49.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,381	18,639	375,367	20.14	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)	205,245	218,044	\$ 2,840,419 *	\$ 13.03	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	\$ 4,360	L1, C3	35
36	Medical Director	Monthly	3,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,880	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	348	4,703	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)	348	\$ 18,943		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3	\$ 114	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3	\$ 114		53

SEE ACCOUNTANTS' COMPILATION REPORT



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)	49,553
Allocated from Real Estate Entity - Accounting	6,000
Allocated from Mangement Company - Legal	6,672
Allocated from Mangement Company - Accounting	2,479
Total ( Agree to Schedule V, Line 19, Column 8)	<u>64,704</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Cahokia Nursing &amp; Rehabilitation Center

# 0039636

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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. IL Council on Long Term Care = \$8,784
- (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. \$ 633 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. \$ 3,767 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? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees

**SEE ACCOUNTANTS' COMPILATION REPORT**