

Facility Name & ID Number St Anthony's Nursing & Rehab Center

0047126 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	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	2,428	1,958	2,866	7,252	8
9	SNF/PED					9
10	ICF	17,899	4,726	1,533	24,158	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,327	6,684	4,399	31,410	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.71%

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)

N/A

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 05/19/05

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

YES Date 05/19/05 NO

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

YES NO If YES, enter number of beds certified 42 and days of care provided 2,173

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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
	A. General Services										
1	Dietary	201,132	14,647	5,798	221,577		221,577		221,577		1
2	Food Purchase		150,707		150,707		150,707		150,707		2
3	Housekeeping	125,774	18,461		144,235		144,235		144,235		3
4	Laundry	49,991	27,208		77,199		77,199		77,199		4
5	Heat and Other Utilities			303,809	303,809		303,809	647	304,456		5
6	Maintenance	120,520		65,275	185,795		185,795	24	185,819		6
7	Other (specify):*										7
8	TOTAL General Services	497,417	211,023	374,882	1,083,322		1,083,322	671	1,083,993		8
	B. Health Care and Programs										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	1,614,254	73,549	5,230	1,693,033		1,693,033	12,182	1,705,215		10
10a	Therapy		101	261,194	261,295		261,295		261,295		10a
11	Activities	60,453	2,175		62,628		62,628		62,628		11
12	Social Services	28,934		2,556	31,490		31,490		31,490		12
13	CNA Training										13
14	Program Transportation			468	468		468		468		14
15	Other (specify):* Mgmt - EE Benefits							1,817	1,817		15
16	TOTAL Health Care and Programs	1,703,641	75,825	291,048	2,070,514		2,070,514	13,999	2,084,513		16
	C. General Administration										
17	Administrative	75,732		87,564	163,296		163,296	(9,124)	154,172		17
18	Directors Fees										18
19	Professional Services			186,997	186,997		186,997	(123,542)	63,455		19
20	Dues, Fees, Subscriptions & Promotions			15,401	15,401		15,401	11,207	26,608		20
21	Clerical & General Office Expenses	91,294	5,373	49,648	146,315		146,315	31,469	177,784		21
22	Employee Benefits & Payroll Taxes			383,089	383,089		383,089		383,089		22
23	Inservice Training & Education							565	565		23
24	Travel and Seminar			3,524	3,524		3,524	8,731	12,255		24
25	Other Admin. Staff Transportation			3,000	3,000		3,000	1,120	4,120		25
26	Insurance-Prop.Liab.Malpractice			70,000	70,000		70,000	1,299	71,299		26
27	Other (specify):* Mgmt - EE Benefits							12,157	12,157		27
28	TOTAL General Administration	167,026	5,373	799,223	971,622		971,622	(66,118)	905,504		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,368,084	292,221	1,465,153	4,125,458		4,125,458	(51,448)	4,074,010		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.

Facility Name & ID Number St Anthony's Nursing & Rehab Center

#0047126

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,336	7,336		7,336	87,675	95,011			30
31	Amortization of Pre-Op. & Org.							6,167	6,167			31
32	Interest			38,849	38,849		38,849	355,058	393,907			32
33	Real Estate Taxes			81,751	81,751		81,751		81,751			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(305,423)	6,577			34
35	Rent-Equipment & Vehicles			7,195	7,195		7,195	1,953	9,148			35
36	Other (specify):*											36
37	TOTAL Ownership			447,131	447,131		447,131	145,430	592,561			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,680		137,680		137,680		137,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* Non-allowable Cos	34,986		21,498	56,484		56,484	(56,484)				43
44	TOTAL Special Cost Centers	34,986	137,680	87,198	259,864		259,864	(56,484)	203,380			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,403,070	429,901	1,999,482	4,832,453		4,832,453	37,498	4,869,951			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

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	(25,569)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,699)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(56,694)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (87,962)		\$	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)	125,460		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 125,460		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 37,498		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

St Anthony's Nursing & Rehab Center

ID# 0047126

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Medicare Radiology	\$ (2,844)	43	1
2	Disallow Medicare Laboratory	(3,525)	43	2
3	Disallow Marketing Salaries	(34,986)	43	3
4	Disallow Penalties	(9,430)	43	4
5	Offset interest income against interest expense	(2)	32	5
6	Disallow non-allowable Chamber of Commerce dues	(333)	21	6
7	Disallow non-allowable Legal fees	(5,000)	19	7
8	Disallow non-allowable PAC dues	(574)	20	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	(56,694)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Anthony's Nursing & Rehab Center# 0047126

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	647	0	0	0	0	0	0	0	0	647	5
6	Maintenance	0	0	24	0	0	0	0	0	0	0	0	24	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	671	0	671	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	12,182	0	0	0	0	0	0	0	0	12,182	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	1,817	0	0	0	0	0	0	0	0	1,817	15
16	TOTAL Health Care and Programs	0	0	13,999	0	13,999	16							
	C. General Administration													
17	Administrative	0	0	(66,731)	0	0	0	0	0	0	0	0	(66,731)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,000)	5,497	(124,039)	0	0	0	0	0	0	0	0	(123,542)	19
20	Fees, Subscriptions & Promotions	(574)	10,950	1,164	0	0	0	0	0	0	0	0	11,540	20
21	Clerical & General Office Expenses	(333)	270	88,806	0	0	0	0	0	0	0	0	88,743	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	565	0	0	0	0	0	0	0	0	565	23
24	Travel and Seminar	0	0	8,731	0	0	0	0	0	0	0	0	8,731	24
25	Other Admin. Staff Transportation	0	0	1,120	0	0	0	0	0	0	0	0	1,120	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,299	0	0	0	0	0	0	0	0	1,299	26
27	Other (specify):*	0	0	12,157	0	0	0	0	0	0	0	0	12,157	27
28	TOTAL General Administration	(5,907)	16,717	(76,928)	0	(66,118)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,907)	16,717	(62,258)	0	(51,448)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Anthony's Nursing & Rehab Center# 0047126

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(25,569)	111,604	1,640	0	0	0	0	0	0	0	0	87,675	30
31	Amortization of Pre-Op. & Org.	0	6,167	0	0	0	0	0	0	0	0	0	6,167	31
32	Interest	(2)	355,060	0	0	0	0	0	0	0	0	0	355,058	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(312,000)	6,577	0	0	0	0	0	0	0	0	(305,423)	34
35	Rent-Equipment & Vehicles	0	0	1,953	0	0	0	0	0	0	0	0	1,953	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(25,571)	160,831	10,170	0	145,430	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(56,484)	0	0	0	0	0	0	0	0	0	0	(56,484)	43
44	TOTAL Special Cost Centers	(56,484)	0	0	0	0	0	0	0	0	0	0	(56,484)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(87,962)	177,548	(52,088)	0	37,498	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Suzanne Koenig	90%	See Schedule 6A		See Schedule 6B		
Gary Weintraub	10%	See Schedule 6A				
				St. Anthony's Property Partners		Building Company

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	\$	St. Anthony's Property Partners	100.00%	\$ 5,497	\$ 5,497	1
2	V	20 Dues, Fees & Subscriptions		St. Anthony's Property Partners	100.00%	10,950	10,950	2
3	V	21 Clerical - Other		St. Anthony's Property Partners	100.00%	270	270	3
4	V	30 Depreciation		St. Anthony's Property Partners	100.00%	111,604	111,604	4
5	V	31 Amortization		St. Anthony's Property Partners	100.00%	6,167	6,167	5
6	V	32 Interest	58,949	St. Anthony's Property Partners	100.00%	414,009	355,060	6
7	V	34 Rent - Facility & Grounds	312,000	St. Anthony's Property Partners	100.00%		(312,000)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 370,949			\$ 548,497	\$ * 177,548	14

* 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	5 Utilities	\$	SAK Management Services, LLC	90.00%	\$ 647	\$	647	15
16	V	6 Maintenance		SAK Management Services, LLC	90.00%	24		24	16
17	V	10 Nursing		SAK Management Services, LLC	90.00%	12,182		12,182	17
18	V	21 Clerical & General		SAK Management Services, LLC	90.00%	57,607		57,607	18
19	V	17 Administrative	87,564	SAK Management Services, LLC	90.00%	20,833		(66,731)	19
20	V	19 Professional Services	130,909	SAK Management Services, LLC	90.00%	6,870		(124,039)	20
21	V	20 Dues, Fees & Subscriptions		SAK Management Services, LLC	90.00%	1,164		1,164	21
22	V	21 Clerical & General		SAK Management Services, LLC	90.00%	5,974		5,974	22
23	V	21 Clerical & General - Salaries		SAK Management Services, LLC	90.00%	25,225		25,225	23
24	V	23 Inservice Training & Education		SAK Management Services, LLC	90.00%	565		565	24
25	V	24 Travel & Seminar		SAK Management Services, LLC	90.00%	5,862		5,862	25
26	V	25 Other Admin. Staff Transportation		SAK Management Services, LLC	90.00%	1,120		1,120	26
27	V	26 Insurance - Property & Liability		SAK Management Services, LLC	90.00%	1,299		1,299	27
28	V	27 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC	90.00%	12,157		12,157	28
29	V	30 Depreciation		SAK Management Services, LLC	90.00%	1,640		1,640	29
30	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	90.00%	6,577		6,577	30
31	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC	90.00%	1,751		1,751	31
32	V	15 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC	90.00%	1,817		1,817	32
33	V	19 Professional Services		SAK Management Services, LLC	90.00%	0			33
34	V	24 Travel & Seminar		SAK Management Services, LLC	90.00%	2,869		2,869	34
35	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC	90.00%	202		202	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 218,473			\$ 166,385	\$ *	(52,088)	39

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

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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	Suzanne Koenig	Owner	Administrative	90.00%	See Attached	10.46	17.43%	Compensation	\$ 20,833	17(7)	1
2	Gary Weintraub	Owner	Administrative	10.00	Not available	N/A	N/A	Legal Services	1,733	19(3)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,566		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 St Anthony's Nursing & Rehab Center

0047126

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 SAK Management Services, LLC
 Street Address 4055 W. Peterson , Suite 101
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 202-0000
 Fax Number (773) 267-0111

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	5	Utilities	SAK Management Fees	1,890,235	8	\$ 5,596	\$ 218,473	\$ 647	1
2	6	Maintenance	SAK Management Fees	1,890,235	8	211	218,473	24	2
3	10	Nursing - Salaries	SAK Management Fees	1,890,235	8	105,396	105,396	12,182	3
4	21	Clerical & General	SAK Management Fees	1,890,235	8	498,418	498,418	57,607	4
5	17	Administrative	SAK Management Fees	1,890,235	8	180,250	218,473	20,833	5
6	19	Professional Services	SAK Management Fees	1,890,235	8	59,442	218,473	6,870	6
7	20	Dues, Fees & Subscriptions	SAK Management Fees	1,890,235	8	10,072	218,473	1,164	7
8	21	Clerical & General	SAK Management Fees	1,890,235	8	51,688	218,473	5,974	8
9	21	Clerical & General - Salaries	SAK Management Fees	1,890,235	8	218,250	218,250	25,225	9
10	23	Inservice Training & Education	SAK Management Fees	1,890,235	8	4,891	218,473	565	10
11	24	Travel & Seminar	SAK Management Fees	1,890,235	8	50,720	218,473	5,862	11
12	25	Other Admin. Staff Transportatio	SAK Management Fees	1,890,235	8	9,694	218,473	1,120	12
13	26	Insurance - Property & Liability	SAK Management Fees	1,890,235	8	11,235	218,473	1,299	13
14	27	Employee Benefits - Mgmt. Co.	SAK Management Fees	1,890,235	8	105,185	218,473	12,157	14
15	30	Depreciation	SAK Management Fees	1,890,235	8	14,188	218,473	1,640	15
16	34	Rent - Facility & Grounds	SAK Management Fees	1,890,235	8	56,907	218,473	6,577	16
17	35	Rent - Equipment & Vehicles	SAK Management Fees	1,890,235	8	15,154	218,473	1,751	17
18	15	Employee Benefits - Mgmt. Co.	SAK Management Fees	1,890,235	8	15,717	218,473	1,817	18
19	19	Professional Services	Direct Cost			122,091		0	19
20	24	Travel & Seminar	Direct Cost			18,959		2,869	20
21	35	Rent - Equipment & Vehicles	Direct Cost			966		202	21
22									22
23									23
24									24
25	TOTALS					\$ 1,555,030	\$ 822,064	\$ 166,385	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center

0047126

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

St Anthony's Nursing & Rehab Center

0047126

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			
A. Directly Facility Related																				
Long-Term																				
1	Cole Taylor Bank		X	Mortgage	Variable	05/19/05	\$ 3,850,000	\$ 3,850,000	04/2008	Prime+1	\$ 346,425	1								
2	United Leasing		X	Lease Payable				2,959				2								
3												3								
4												4								
5												5								
Working Capital																				
6	Cole Taylor Bank		X	Revolving Line of Credit	Varies	05/20/05		480,000	04/2008	Variable	38,849	6								
7	Monroe Capital		X	Line of Credit	Varies	05/19/05		305,739	05/19/08	0.0925	37,423	7								
8												8								
9	TOTAL Facility Related						\$ 3,850,000	\$ 4,638,698			\$ 422,697	9								
B. Non-Facility Related*																				
10											30,161	10								
11											(2)	11								
12											(58,949)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (28,790)	14								
15	TOTALS (line 9+line14)						\$ 3,850,000	\$ 4,638,698			\$ 393,907	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.		\$	69,339	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	\$	69,864	2
3. Under or (over) accrual (line 2 minus line 1).		\$	525	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	119,539	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			(38,313)	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	81,751	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	_____	8	
	2003	_____	9	
	2004	67,371	10	
	2005	70,072	11	
	2006	69,864	12	
Accrual is last years taxes adjusted for inflation.				
FOR BHF USE ONLY				
	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 St Anthony's Nursing & Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Suzanne Koenig

TELEPHONE (773) 202-0000 FAX #: (773) 267-0111

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>09-231-19-00</u>	<u>Long Term Care Property</u>	\$ <u>1,299.24</u>	\$ <u>1,299.24</u>
2. <u>09-175-06-00</u>	<u>Long Term Care Property</u>	\$ <u>68,564.80</u>	\$ <u>68,564.80</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>69,864.04</u>	\$ <u>69,864.04</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.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 149,308 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 5

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>319,300</u>	<u>2005</u>	<u>\$ 150,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	319,300		\$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	120		2005	1974	\$ 2,050,000	\$	35	\$ 58,571	\$ 58,571	\$ 175,713	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security & Monitoring System		2005		3,522	617	20	176	(441)	680	9
10	Boiler		2005		24,087	4,222	10	2,409	(1,813)	6,023	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

*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	2,077,609	\$	4,839	\$	61,156	\$	56,317	\$	182,416	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	\$ 311,806	\$ 2,497	\$ 31,913	\$ 29,416		\$ 95,866	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Management Company			1,640	1,640			74
75	TOTALS	\$ 311,806	\$ 2,497	\$ 33,553	\$ 31,056		\$ 95,866	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford Winstar	2005	\$ 1,506	\$	\$ 302	\$ 302	5	\$ 604	76
77										77
78										78
79										79
80	TOTALS			\$ 1,506	\$	\$ 302	\$ 302		\$ 604	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)	\$ 2,540,921	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,336	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,011	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 87,675	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 278,886	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 353,557	92
93			93
94			94
95		\$ 353,557	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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6		<u>Allocated from Management Company</u>			<u>6,577</u>			6
7	TOTAL				\$ <u>6,577</u>			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: \$ \$ 9,148 Description: Copier Rental - \$4,638; Postage Meter - \$2,149; Medical Equipment - \$408; Mgmt Allocation - \$1953

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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	10A(2,3)	hrs	\$	1,611	\$ 96,668	\$ 101	1,611	\$ 96,769	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		208	12,456		208	12,456	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,535	152,070		2,535	152,070	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				118,718		118,718	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39(2)					18,962		18,962	13
14	TOTAL			\$	4,354	\$ 261,194	\$ 137,781	4,354	\$ 398,975	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

St. Anthony's Nursing & Rehabilitation Center

Provider #: 0047126

1/1/2007 to 12/31/2007

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 9 - Other (specify)		
Real Estate Tax Escrow - C.T.	0	133,164
Employee Loans, Adv., Wage Assignment	137	137
Due to Medicare	16,076	16,076
	<u>16,213</u>	<u>149,377</u>
Line 22 - Other Long Term Assets (specify)		
Construction Reserve - C.T.	0	142,711
Construction In Process	0	210,846
Total Line 22 - Other Long Term Assets	<u>0</u>	<u>353,557</u>
Line 36 - Other Current Liabilities (specify)		
Due from St. Anthony's Nursing & Rehab	0	(402,553)
Iowa State Withholding	(132)	(132)
Due to St. Anthony's Property, LLC	402,553	402,553
Due to Lessor/Prior Owner	33,019	33,019
Trust Account Liability	22,202	22,202
Total Line 36 - Other Current Liabilities	<u>457,642</u>	<u>55,089</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (60,170)	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	7,179	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (52,991)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(550,822)	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)	\$ (550,822)	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)	\$ (603,813)	24 *

* 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	\$ 3,600,415	1
2	Discounts and Allowances for all Levels	(20,183)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,580,232	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	595,428	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 595,428	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	91,384	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,754	19
20	Radiology and X-Ray	1,798	20
21	Other Medical Services	10,189	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 105,125	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Commission 703, Miscellaneous 141</u>	844	28
28a	<u>Rental Income - Nextel & Parking</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 844	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,281,631	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,083,322	31
32	Health Care	2,070,514	32
33	General Administration	971,622	33
	B. Capital Expense		
34	Ownership	447,131	34
	C. Ancillary Expense		
35	Special Cost Centers	194,164	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,832,453	40
41	Income before Income Taxes (line 30 minus line 40)**	(550,822)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (550,822)	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.
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 **St Anthony's Nursing & Rehab Center**

0047126

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	1,888	2,000	\$ 53,109	\$ 26.55	1
2	Assistant Director of Nursing	1,904	2,080	41,545	19.97	2
3	Registered Nurses	2,960	3,106	69,154	22.26	3
4	Licensed Practical Nurses	31,747	33,682	571,704	16.97	4
5	CNAs & Orderlies	68,848	73,311	740,142	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,911	6,566	60,453	9.21	10
11	Social Service Workers	1,912	2,038	28,934	14.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,479	20,918	201,132	9.62	15
16	Dishwashers					16
17	Maintenance Workers	10,490	11,252	120,520	10.71	17
18	Housekeepers	14,254	15,225	125,774	8.26	18
19	Laundry	6,476	6,861	49,991	7.29	19
20	Administrator	1,920	2,080	75,732	36.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,778	6,223	91,294	14.67	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	2,176	2,381	23,273	9.77	31
32	Other Health C: See Sch 20A	5,872	6,300	115,327	18.31	32
33	Other(specify) <u>Marketing</u>	2,016	2,136	34,986	16.38	33
34	TOTAL (lines 1 - 33)	183,631	196,159	\$ 2,403,070 *	\$ 12.25	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	\$ 5,798	1(3)	35
36	Medical Director	Monthly	21,600	9(3)	36
37	Medical Records Consultant	Monthly	4,200	10(3)	37
38	Nurse Consultant			10(3)	38
39	Pharmacist Consultant	Monthly	600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,556	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 34,754		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

St. Anthony's Rehabilitation & Nursing Center

Provider #: 0047126

1/1/2007 to 12/31/2007

Schedule 20A

	Hours Worked	Hours Paid	Total Wages	Ave. Hrly. Wage
XVIII. Staffing & Salary Costs				
Line 32 - Other				
Restorative Aide	2,040	2,196	23,065	10.50
Care Plan Coordinator	3,832	4,104	92,262	22.48
	<u>5,872</u>	<u>6,300</u>	<u>115,327</u>	<u>18.31</u>

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>Kimberly Hufsey</u>	<u>Administrator</u>	<u>0</u>	\$ <u>75,732</u>	<u>Workers' Compensation Insurance</u>	\$ <u>52,016</u>	<u>IDPH License Fee</u>	\$ <u>995</u>	
				<u>Unemployment Compensation Insurance</u>	<u>45,185</u>	<u>Advertising: Employee Recruitment</u>	<u>2,726</u>	
				<u>FICA Taxes</u>	<u>180,188</u>	<u>Health Care Worker Background Check</u>	<u>2,640</u>	
				<u>Employee Health Insurance</u>	<u>99,866</u>	(Indicate # of checks performed <u>264</u>)	<u>2,640</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>81</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>IL Council on Long Term Care</u>	<u>6,984</u>	
				<u>Employee Morale</u>	<u>5,470</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>368</u>	
				<u>Other Employee Benefits</u>	<u>364</u>	<u>Miscellaneous Licenses & Permits</u>	<u>878</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>75,732</u>			<u>Allocated from Real Estate Entity</u>	<u>10,950</u>	
(List each licensed administrator separately.)						<u>Allocated from Management Company</u>	<u>1,164</u>	
B. Administrative - Other						Less: Public Relations Expense	(907)	
Description			Amount			<u>Non-allowable advertising</u>	<u>()</u>	
<u>SAK Management Services, LLC - Management Fees</u>			\$ <u>87,564</u>			<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>87,564</u>	TOTAL (agree to Schedule V,	\$ <u>383,089</u>	TOTAL (agree to Sch. V,	\$ <u>26,608</u>	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Personnel Planners Inc.</u>	<u>Unemployment Consult.</u>		\$ <u>1,360</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	\$ <u>()</u>
<u>Joseph Abramchik</u>	<u>Operations Consulting</u>		<u>24,450</u>					
<u>Alpha Data Services, LLC</u>	<u>Payroll Processing</u>		<u>5,555</u>					
<u>Emdeon Business Services</u>	<u>Computer Services</u>		<u>84</u>				<u>In-State Travel</u>	
<u>Health Data Systems, Inc.</u>	<u>Computer Services</u>		<u>6,711</u>					
<u>Ivans, Inc.</u>	<u>Computer Services</u>		<u>2,272</u>					
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>1,300</u>					
<u>Duane Morris, LLP</u>	<u>Legal</u>		<u>7,500</u>				<u>Seminar Expense</u>	
<u>Gary A. Weintraub, P.C.</u>	<u>Legal</u>		<u>1,733</u>				<u>See Attached Schedule</u>	<u>3,524</u>
<u>Michael J. Warner & Associates</u>	<u>Legal</u>		<u>846</u>					
<u>SAK Management Services</u>	<u>Bookkeeping Services</u>		<u>130,909</u>				<u>Allocated from Management Company</u>	<u>8,731</u>
<u>FR&R</u>	<u>Accounting Fees</u>		<u>4,277</u>				<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>186,997</u>	TOTAL		\$ <u>()</u>	TOTAL (agree to Sch. V,	\$ <u>12,255</u>
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

St. Anthony's Nursing & Rehab Center
Facility ID#: 0047126
Schedule XIX
12/31/2007

Schedule 21A

Schedule XIX (C) - Professional Fees.

TOTAL (agree to Schedule V, line 19, column 3)	186,997
Allocation from SAK - Legal	3,709
Allocation from SAK - Data Processing	969
Allocation from SAK - Other Consulting	2,192
Offset SAK Bookkeeping Fees	(130,909)
Allocation from Real Estate Entity	5,497
Less: Disallowed legal fees	<u>(5,000)</u>
TOTAL (agree to Schedule V, line 19, column 8)	<u><u>63,455</u></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								
FY2004					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	
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 St Anthony's Nursing & Rehab Center# 0047126Report Period Beginning: 01/01/2007Ending: 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 - \$6,410
- (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? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,885 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. \$ 65,700
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 13%
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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
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