

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	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	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	6,963	111	4,925	11,999	8	
9	SNF/PED					9	
10	ICF	28,164	1,391	675	30,230	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	35,127	1,502	5,600	42,229	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.92%

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 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 30 and days of care provided 2,381

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	221,140	20,567	3,414	245,121		245,121		245,121		1
2	Food Purchase		236,436		236,436		236,436	(15,529)	220,907		2
3	Housekeeping	143,198	72,223		215,421		215,421	120	215,541		3
4	Laundry	97,134	29,927		127,061		127,061		127,061		4
5	Heat and Other Utilities			167,076	167,076		167,076	1,174	168,250		5
6	Maintenance	42,414	63,805	11,365	117,584		117,584	2,590	120,174		6
7	Other (specify):*										7
8	TOTAL General Services	503,886	422,958	181,855	1,108,699		1,108,699	(11,645)	1,097,054		8
	B. Health Care and Programs										
9	Medical Director			2,750	2,750		2,750		2,750		9
10	Nursing and Medical Records	1,778,050	50,056	6,717	1,834,823		1,834,823	7,534	1,842,357		10
10a	Therapy			377,440	377,440		377,440		377,440		10a
11	Activities	64,515	7,909		72,424		72,424		72,424		11
12	Social Services	49,909			49,909		49,909		49,909		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,892,474	57,965	386,907	2,337,346		2,337,346	7,534	2,344,880		16
	C. General Administration										
17	Administrative	212,159		127,678	339,837		339,837	(81,278)	258,559		17
18	Directors Fees										18
19	Professional Services			53,452	53,452		53,452	10,109	63,561		19
20	Dues, Fees, Subscriptions & Promotions			11,536	11,536		11,536	(3,773)	7,763		20
21	Clerical & General Office Expenses	392,533		40,622	433,155		433,155	36,747	469,902		21
22	Employee Benefits & Payroll Taxes			350,391	350,391		350,391	5,015	355,406		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,418	1,418		1,418	13	1,431		24
25	Other Admin. Staff Transportation			2,830	2,830		2,830	1,189	4,019		25
26	Insurance-Prop.Liab.Malpractice			83,070	83,070		83,070	19,927	102,997		26
27	Other (specify):* Mgmt. Alloc of Benefi							14,891	14,891		27
28	TOTAL General Administration	604,692		670,997	1,275,689		1,275,689	2,840	1,278,529		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,001,052	480,923	1,239,759	4,721,734		4,721,734	(1,271)	4,720,463		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 Cahokia Nursing & Rehabilitation Center

#0039636

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			39,853	39,853		39,853	93,983	133,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,326	24,326		24,326	215,711	240,037			32
33	Real Estate Taxes							219,658	219,658			33
34	Rent-Facility & Grounds			600,000	600,000		600,000	(600,000)				34
35	Rent-Equipment & Vehicles							1,041	1,041			35
36	Other (specify):* Mortgage Insurance							18,686	18,686			36
37	TOTAL Ownership			664,179	664,179		664,179	(50,921)	613,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,904		91,904		91,904		91,904			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):* Non-allowable cost			31,645	31,645		31,645	(31,645)				43
44	TOTAL Special Cost Centers		91,904	113,995	205,899		205,899	(31,645)	174,254			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,001,052	572,827	2,017,933	5,591,812		5,591,812	(83,837)	5,507,975			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	2,740	30		9
10	Interest and Other Investment Income	(23,930)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(268)	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				18
19	Entertainment				19
20	Contributions	(910)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(210)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,336)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,200)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	348	43		28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(14,134)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (53,900)		\$	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)	(29,937)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (29,937)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (83,837)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center

ID# 0039636

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Chamber of Commerce Dues	\$ (100)	20	1
2	Lab Expense-Med A	(10,987)	43	2
3	X-Ray Expense-Med A	(2,292)	43	3
4	Association Fees	(3,825)	20	4
5	Real Estate Taxes	3,070	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	Total	(14,134)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule 6A		See Schedule 6B		See Schedule 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Services	\$	Cahokia Building LLC	100.00%	\$ 6,500	\$ 6,500	1
2	V	21 Clerical & General Office-Other		Cahokia Building LLC	100.00%	176	176	2
3	V	26 Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	19,365	19,365	3
4	V	30 Depreciation		Cahokia Building LLC	100.00%	88,393	88,393	4
5	V	32 Interest Income	396	Cahokia Building LLC	100.00%		(396)	5
6	V	32 Interest		Cahokia Building LLC	100.00%	235,725	235,725	6
7	V	33 Real Estate Tax		Cahokia Building LLC	100.00%	213,089	213,089	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%	18,686	18,686	9
10	V	21 Miscellaneous Income	3,286	Cahokia Building LLC	100.00%		(3,286)	10
11	V	32 Amortization		Cahokia Building LLC	100.00%	4,312	4,312	11
12	V							12
13	V							13
14	Total		\$ 603,682			\$ 586,246	\$ * (17,436)	14

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

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

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

Out-of-State:

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

Other Related Business Entities

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 8	\$ 8
16	V	3 Housekeeping		SW Management Co.	100.00%	120	120
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,174	1,174
18	V	6 Maintenance		SW Management Co.	100.00%	2,590	2,590
19	V	17 Administrative	127,678	SW Management Co.	100.00%	46,400	(81,278)
20	V	19 Professional Services		SW Management Co.	100.00%	3,864	3,864
21	V	20 Dues,Fees,Subs & Promotions		SW Management Co.	100.00%	107	107
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	39,857	39,857
23	V	24 Travel and Seminar		SW Management Co.	100.00%	13	13
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	1,189	1,189
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	562	562
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	14,891	14,891
27	V	30 Depreciation		SW Management Co.	100.00%	2,850	2,850
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,499	3,499
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,041	1,041
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 127,678			\$ 118,165	\$ * (9,513)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 27,603	S & E Medical Supply Co.	100.00%	\$ 17,081	\$ (10,522)
16	V	3 Housekeeping	1,822	S & E Medical Supply Co.	100.00%	1,822	
17	V	10 Medical Supplies	2,873	S & E Medical Supply Co.	100.00%	10,407	7,534
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		\$ 32,298			\$ 29,310	\$ * (2,988)

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	7.50	Salary	\$ 13,920	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	5	10.00	Salary&Fees	18,560	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	7.50	Salary	13,920	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	\$ 46,400		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:

01/01/2008

Ending: 12/31/2008

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	657,492	12	\$ 98	\$ 54,900	\$ 8	1	
2	3	Housekeeping	Bed Days Available	657,492	12	1,440	54,900	120	2	
3	5	Heat and Other Utilities	Bed Days Available	657,492	12	14,061	54,900	1,174	3	
4	6	Maintenance	Bed Days Available	657,492	12	31,014	54,900	2,590	4	
5	19	Professional Services	Bed Days Available	657,492	12	46,281	54,900	3,864	5	
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	657,492	12	1,278	54,900	107	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,492	12	477,338	410,633	39,857	7	
8	24	Travel and Seminar	Bed Days Available	657,492	12	157	54,900	13	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,492	12	14,238	54,900	1,189	9	
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	657,492	12	6,729	54,900	562	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,492	12	178,342	54,900	14,891	11	
12	33	Real Estate Taxes	Bed Days Available	657,492	12	41,904	54,900	3,499	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,492	12	12,467	54,900	1,041	13	
14									14	
15									15	
16									16	
17	17	Administrative	Avg Hours Worked	40	11	371,200	371,200	3	27,840	17
18		Administrative	Avg Hours Worked	50	6	185,600	185,600	5	18,560	18
19									19	
20	30	Depreciation	Direct Cost					2,850	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 118,165	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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		\$	\$		\$ 17,081	1
2	3	Housekeeping	Direct Cost					1,822	2
3	10	Medical Supplies	Direct Cost					10,407	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				\$	\$		\$ 29,310	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Heartland Bank-HUD		X	Mortgage	\$23,524.00	11/27/01	\$ 3,961,000	\$ 3,690,740	12/01/36	0.0635	\$ 235,725	1					
2												2					
3											Amortization of Mortgage Costs	4,312	3				
4												4					
5												5					
Working Capital																	
6	N/P Stockholders	X		Working Capital				400,000				24,326	6				
7													7				
8													8				
9	TOTAL Facility Related				\$23,524.00		\$ 3,961,000	\$ 4,090,740				\$ 264,363	9				
B. Non-Facility Related*																	
10													10				
11											Related Party Interest Expense net of Interest Income	(13,104)	11				
12											Interest Income Offset	(10,826)	12				
13											Interest Income from Real Estate Entity	(396)	13				
14	TOTAL Non-Facility Related						\$	\$				\$ (24,326)	14				
15	TOTALS (line 9+line14)						\$ 3,961,000	\$ 4,090,740				\$ 240,037	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,686 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 2007 report.		\$	189,000	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.)	2007	\$	201,159	2
3. Under or (over) accrual (line 2 minus line 1).		\$	12,159	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	204,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	3,499	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	219,658	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	143,835	8	
	2004	160,219	9	
	2005	177,414	10	
	2006	179,854	11	
	2007	201,159	12	
2008 RE Tax Accrual = 201,159 X 1.015 = 204,176. Use 204,000.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

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

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

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

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-02.0-310-055</u>	<u>Long term care property</u>	\$ <u>198,088.62</u>	\$ <u>198,088.62</u>
2. <u>06-02.0-310-054</u>	<u>Long term care property</u>	\$ <u>3,070.08</u>	\$ <u>3,070.08</u>
3. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>43,500.34</u>	\$ <u>3,499.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>244,659.04</u>	\$ <u>204,657.70</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? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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:

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Rows include Resident Care, Office Space for Employees, and TOTALS.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	2001		\$ 2,928,441	\$	15-40	\$ 80,744	\$ 80,744	\$ 573,843	4
5		2006		55,818	2,030	40	1,431	(599)	3,578	5
6										6
7	Allocated from Management Co.	1995		36,141		39	1,033	1,033	13,068	7
8										8
	Improvement Type**									
9	Various		1994	17,857	268	20	523	255	14,895	9
10	Various		1995	33,623	337	20	1,681	1,344	23,093	10
11	Various		1996	2,178	56	20	109	53	1,381	11
12	Various		1997	9,423		20	471	471	5,421	12
13	Various		1998	4,800	123	20	240	117	2,520	13
14	Various		1999	16,266	93	20	813	720	7,911	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	494	18
19	Fan Motor		2001	1,123		20	56	56	397	19
20	Drywall-Dining Room		2002	10,650	184	10	1,065	881	7,278	20
21	Door		2002	9,860	184	20	493	309	2,999	21
22	Air Conditioner		2002	1,198		7	171	171	1,127	22
23	Air Conditioner		2002	1,582		7	226	226	1,488	23
24	Air Conditioners		2002	4,284		7	612	612	3,978	24
25	Compressor Air Maxi		2002	1,269		7	181	181	1,208	25
26	Roof - New		2003	97,996	2,513	20	4,900	2,387	28,174	26
27	Nursing Station		2003	35,060		20	1,753	1,753	9,349	27
28	Nursing Station		2003	28,692		20	1,435	1,435	8,847	28
29	Nursing Station		2003	6,368		20	318	318	1,619	29
30	Replace Accelerator		2003	968		20	48	48	290	30
31	Sprinkler System		2004	3,610	131	20	181	50	813	31
32	Smoke shelter		2004	6,041	220	20	302	82	1,359	32
33	Security System		2005	11,166	406	20	558	152	1,954	33
34	Condensing Unit - 5 Ton		2005	1,959	71	20	98	27	343	34
35	Cabinets and countertops		2005	110,923	4,011	20	5,546	1,535	19,411	35
36	Air Handler		2005	1,549	56	20	78	22	272	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$ 429	20	\$ 279	\$ (151)	\$ 975	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	192	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	735	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	769	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	256	41
42	Door Alarms	2005	3,587	130	20	179	49	627	42
43	Wallpaper	2005	17,835		20	892	892	3,121	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	5,180	44
45	6 Doors	2005	1,926	70	20	96	26	337	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	1,819	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	854	47
48	Duct Heater	2006	1,195	43	20	60	17	150	48
49	Kitchen Garbage Disposal	2006	1,467	282	20	73	(209)	183	49
50	Copper Pipe & Concrete	2006	3,722	135	20	186	51	465	50
51	Fence	2006	6,061	518	20	303	(215)	758	51
52	Shower Remodel - Hall 400	2006	21,570	784	20	1,079	295	2,697	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	1,219	53
54	Shower Remodel - Hall 200	2006	21,570	784	20	1,079	295	2,697	54
55	Shower Remodel - Hall 500	2006	21,570	784	20	1,079	295	2,697	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	2,447	56
57	Front Entrance	2006	2,150	78	20	108	30	269	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	420	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	216	59
60	Compressor-Walk In Freezer	2006	1,784	65	20	89	24	223	60
61	Air Conditioners (5)	2006	2,146	412	10	215	(197)	537	61
62	Air Conditioners (6)	2006	2,576	494	20	129	(365)	322	62
63	Phone System	2006	1,658	318	20	83	(235)	207	63
64	Remove & reinstall 6 dry pendants	2007	3,039	111	20	152	41	228	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	563	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	158	43	237	66
67	New Window Glass	2007	3,562	130	20	178	48	267	67
68	Paving, Parking Lot & Driveway	2007	32,275	3,066	20	1,614	(1,452)	2,421	68
69	Handrails	2007	2,980		20	149	149	224	69
70	TOTAL (lines 4 thru 69)		\$ 3,704,135	\$ 21,757		\$ 118,207	\$ 96,450	\$ 776,055	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		\$ 3,704,135	\$ 21,757		\$ 118,207	\$ 96,450	\$ 776,055	1
2	Fire Damper and Roof Vent	2007	5,114	186	20	256	70	384	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790		20	440	440	660	3
4	Walk In Freezer Door	2007	2,316	84	20	115	31	173	4
5	Replace 4 Inch Main	2008	3,158	43	20	79	36	79	5
6	Sprinkler heads for alarm	2008	29,310	311	20	733	422	733	6
7	Sign	2008	2,685	2,685	20	67	(2,618)	67	7
8									8
9	Allocated from SW Management - Leasehold Improvements	1995	3,855		20	191	191	2,905	9
10	Allocated from SW Management - Leasehold Improvements	1996	673		20	34	34	423	10
11	Allocated from SW Management - Leasehold Improvements	1997	970		20	49	49	677	11
12	Allocated from SW Management - Leasehold Improvements	1998	668		20	33	33	359	12
13	Allocated from SW Management - Leasehold Improvements	1999	1,854		20	93	93	842	13
14	Allocated from SW Management - Leasehold Improvements	2005	3,835		20	192	192	671	14
15	Allocated from SW Management - Leasehold Improvements	2007	2,171		20	109	109	163	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)		\$ 3,769,534	\$ 25,066		\$ 120,597	\$ 95,531	\$ 784,191	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	\$ 753,567	\$ 7,562	\$ 11,762	\$ 4,200	10	\$ 543,187	71
72	Current Year Purchases	7,225	7,225	361	(6,864)	10	361	72
73	Fully Depreciated Assets	114,995					114,995	73
74	Allocation from Mgmt. Co.	11,412		148	148	10	8,364	74
75	TOTALS	\$ 887,199	\$ 14,787	\$ 12,271	\$ (2,516)		\$ 666,907	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	Cadillac	2004	\$ 4,840	\$	\$ 968	\$ 968	5	\$ 4,356	76
77										77
78										78
79										79
80	TOTALS			\$ 4,840	\$	\$ 968	\$ 968		\$ 4,356	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)	\$ 4,906,573	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,853	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 133,836	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 93,983	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,455,454	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		\$	\$ 1,041	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,041	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	2,364	\$ 132,377	\$	2,364	\$ 132,377	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,520	91,206		1,520	91,206	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,923	152,009		2,923	152,009	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				57,946		57,946	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Oxygen</u>	L39, C2					33,958		33,958	13
14	TOTAL			\$	6,807	\$ 375,592	\$ 91,904	6,807	\$ 467,496	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: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,000	\$ 1,000	1
2	Cash-Patient Deposits	36,838	36,838	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	1,026,276	1,434,790	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,267	20,569	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch. 17A	63,265	320,452	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,141,646	\$ 1,813,649	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	3,020,400	14
15	Leasehold Improvements, at Historical Cost	598,079	749,134	15
16	Equipment, at Historical Cost	392,914	892,039	16
17	Accumulated Depreciation (book methods)	(536,431)	(1,455,454)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): See Pg. 17A		120,940	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 525,380	\$ 3,572,059	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,667,026	\$ 5,385,708	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 166,349	\$ 124,920	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,189	41,189	28
29	Short-Term Notes Payable	400,000	400,000	29
30	Accrued Salaries Payable	65,384	65,384	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,222	9,222	31
32	Accrued Real Estate Taxes(Sch.IX-B)		204,000	32
33	Accrued Interest Payable		19,530	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch. 17A	557,245	557,245	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,239,389	\$ 1,421,490	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,690,740	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,690,740	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,239,389	\$ 5,112,230	46
47	TOTAL EQUITY(page 18, line 24)	\$ 427,637	\$ 273,478	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,667,026	\$ 5,385,708	48

Cahokia Nursing & Rehabilitation Center, Inc.
Provider #: 0039636
12/31/2008

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	After	
	Operating	Consolidation
RE Replacement Reserve	-	159,126
RE Escrow Real Estate Tax	-	98,061
Employee Payroll Advance	-	-
Reimbursement Due	(243,567)	(243,567)
Short Term Loan Exchange	306,832	306,832
Total Line 9-Other Current Assets (Specify)	63,265	320,452

Other Long-Term Assets (Specify)

RE Capitalized Costs	-	150,935
RE Accumulated Amortization	-	(29,995)
Total Line 22-Other Long-Term Assets (specify)	-	120,940

Other Current Liabilities (Specify)

Insurance Premiums Payable	(7,568)	(7,568)
Acc. Retirement (From P/R)	1,365	1,365
Accrued Expenses	108,492	108,492
Due to Public Aid	1,086	1,086
Due/From Cahokia Property	439,697	439,697
Due/From Vacant Cahokia Property	14,173	14,173
Total Line 36-Other Current Liabilities (Specify)	557,245	557,245

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 443,468	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 443,468	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(15,830)	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) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (15,831)	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)	\$ 427,637	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	\$ 5,146,207	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,146,207	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	394,476	6
7	Oxygen	23,999	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 418,475	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	474	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 474	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,826	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,826	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,575,982	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,108,699	31
32	Health Care	2,337,346	32
33	General Administration	1,275,689	33
	B. Capital Expense		
34	Ownership	664,179	34
	C. Ancillary Expense		
35	Special Cost Centers	123,549	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,591,812	40
41	Income before Income Taxes (line 30 minus line 40)**	(15,830)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (15,830)	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: 01/01/2008

Ending: 12/31/2008

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	1,824	2,080	\$ 60,231	\$ 28.96	1
2	Assistant Director of Nursing	2,008	2,160	55,786	25.83	2
3	Registered Nurses	2,495	2,668	63,780	23.91	3
4	Licensed Practical Nurses	26,847	28,535	561,382	19.67	4
5	CNAs & Orderlies	91,672	96,684	937,072	9.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,755	8,620	99,799	11.58	8
9	Activity Director					9
10	Activity Assistants	6,160	6,448	64,515	10.01	10
11	Social Service Workers	4,056	4,197	49,909	11.89	11
12	Dietician					12
13	Food Service Supervisor	1,777	2,017	28,309	14.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,212	21,870	192,831	8.82	15
16	Dishwashers					16
17	Maintenance Workers	3,474	3,632	42,414	11.68	17
18	Housekeepers	17,244	18,317	143,198	7.82	18
19	Laundry	11,814	12,313	97,134	7.89	19
20	Administrator	4,048	4,320	212,159	49.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,231	19,677	392,533	19.95	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)	219,617	233,538	\$ 3,001,052 *	\$ 12.85	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	\$ 3,414	L1, C3	35
36	Medical Director	Monthly	2,750	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,717	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	137	1,848	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)	137	\$ 14,729		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

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			
Teresa Ruberg	Administrator	0	\$ 212,159	Workers' Compensation Insurance	\$ 34,345	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	35,308	Advertising: Employee Recruitment				
				FICA Taxes	227,053	Health Care Worker Background Check				
				Employee Health Insurance	54,673	(Indicate # of checks performed 89)	1,066			
				Employee Meals	5,015	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	5,250			
				Tuition Reimbursement	450	Miscellaneous Dues & Permits	2,045			
				Miscellaneous Employee Benefits	(1,438)	Miscellaneous Inspections & Licenses	1,130			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 212,159	TOTAL (agree to Schedule V, line 22, col.8)			\$ 355,406	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,763
(List each licensed administrator separately.)								Less: Non-Allowable Dues		(3,825)
B. Administrative - Other							Less: Public Relations Expense		()	
Description			Amount				Non-allowable advertising		()	
SW Management-Home Office & Management Fees			\$ 7,678				Yellow page advertising		()	
Ronnie Klein-Management Fees			120,000							
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 127,678							
(Attach a copy of any management service agreement)										
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		
Helper,Broom,MacDonald,Hebrank	Legal		\$ 25,180	N/A			Out-of-State Travel	\$		
Ashman & Stein	Legal		1,785							
Stone, Mcguire & Siegel	Legal		4,819							
Cynthia Fleck	Legal		3,900				In-State Travel			
Michael Polinsky	Legal		1,500							
Catherine Wittgen	Legal		675							
Illinois Notary	Legal		45							
McGladrey & Pullen, LLP	Accounting		712				Seminar Expense	1,418		
Personnel Planners	Unemployment Consulting		14,836				Allocation from Management Co.	13		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 53,452	TOTAL			\$	Entertainment Expense	()	
(If total legal fees exceed \$5,000, attach copy of invoices.)								(agree to Sch. V, line 24, col. 8)		\$ 1,431

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Cahokia Nursing & Rehabilitation Center
Provider # : 0039636
12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	53,452
Reclass Notary fees to dues & subscriptions	(45)
Disallow out of period legal expenses	(210)
Allocated from Real Estate Entity - Accounting	6,500
Allocated from Mangement Company - Legal	3,030
Allocated from Mangement Company - Accounting	834
Total (Agree to Schedule V, Line 19, Column 8)	<u>63,561</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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 = \$5,250
- (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. \$ 215 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. \$ 82,350
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. \$ 5,015 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? 0
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