

		FOR BHF USE				

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0047126</u></p> <p>Facility Name: <u>St Anthony's Nursing & Rehab Center</u></p> <p>Address: <u>767 30th Street</u> <u>Rock Island</u> <u>61201</u> <small>Number City Zip Code</small></p> <p>County: <u>Rock Island</u></p> <p>Telephone Number: <u>(309) 788-7631</u> Fax # <u>(309) 788-9823</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>05/19/05</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 789-7700</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) _____</td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____		(Type or Print Name) _____		(Date) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701</u>		(Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

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

0047126 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 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	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,548	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	994	966	4,110	6,070	8
9	SNF/PED					9
10	ICF	18,638	5,703	2,434	26,775	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,632	6,669	6,544	32,845	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.78%

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 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 3,757

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: 12/31/08 Fiscal Year: 12/31/08
* 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: **01/01/2008** 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
1	A. General Services										
1	Dietary	211,868	15,141	5,458	232,467		232,467		232,467		1
2	Food Purchase		169,659		169,659		169,659		169,659		2
3	Housekeeping	118,994	22,337		141,331		141,331		141,331		3
4	Laundry	59,553	30,276		89,829		89,829		89,829		4
5	Heat and Other Utilities			318,627	318,627		318,627	690	319,317		5
6	Maintenance	130,275		75,107	205,382		205,382		205,382		6
7	Other (specify):*										7
8	TOTAL General Services	520,690	237,413	399,192	1,157,295		1,157,295	690	1,157,985		8
9	B. Health Care and Programs										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	1,751,366	85,940	6,168	1,843,474		1,843,474	257	1,843,731		10
10a	Therapy	60,109	33	316,442	376,584		376,584		376,584		10a
11	Activities	62,073	2,063	660	64,796		64,796		64,796		11
12	Social Services	31,019		1,808	32,827		32,827		32,827		12
13	CNA Training										13
14	Program Transportation			210	210		210		210		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,904,567	88,036	346,888	2,339,491		2,339,491	257	2,339,748		16
17	C. General Administration										
17	Administrative	81,497		98,575	180,072		180,072	(98,575)	81,497		17
18	Directors Fees										18
19	Professional Services			187,496	187,496		187,496	(139,217)	48,279		19
20	Dues, Fees, Subscriptions & Promotions			25,174	25,174		25,174	431	25,605		20
21	Clerical & General Office Expenses	84,622	5,745	97,758	188,125		188,125	8,074	196,199		21
22	Employee Benefits & Payroll Taxes			422,524	422,524		422,524		422,524		22
23	Inservice Training & Education							1,642	1,642		23
24	Travel and Seminar			3,334	3,334		3,334	11,456	14,790		24
25	Other Admin. Staff Transportation			4,991	4,991		4,991	1,127	6,118		25
26	Insurance-Prop.Liab.Malpractice			70,000	70,000		70,000	1,412	71,412		26
27	Other (specify):* Mgmt - EE Benefits							44,707	44,707		27
28	TOTAL General Administration	166,119	5,745	909,852	1,081,716		1,081,716	(168,943)	912,773		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,591,376	331,194	1,655,932	4,578,502		4,578,502	(167,996)	4,410,506		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			10,777	10,777		10,777	85,409	96,186			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,778	43,778		43,778	204,872	248,650			32
33	Real Estate Taxes			81,751	81,751		81,751		81,751			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(303,928)	8,072			34
35	Rent-Equipment & Vehicles			10,913	10,913		10,913	2,143	13,056			35
36	Other (specify):*											36
37	TOTAL Ownership			459,219	459,219		459,219	(11,504)	447,715			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			189,646	189,646		189,646		189,646			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,699	66,699		66,699		66,699			42
43	Other (specify):* Non-allowable cost	37,679		389,759	427,438		427,438	(427,438)				43
44	TOTAL Special Cost Centers	37,679	189,646	456,458	683,783		683,783	(427,438)	256,345			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,629,055	520,840	2,571,609	5,721,504		5,721,504	(606,938)	5,114,566			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	(27,709)	30		9
10 Interest and Other Investment Income	(17)	32		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 Retainer				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(357,000)	43		24
25 Fund Raising, Advertising and Promotional	(7,742)	43		25
Income Taxes and Illinois Persona				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Pg 5A	(113,882)	Vari.		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (506,350)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
Amortization of Organization & Pre-Operating Expense			
33			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	(100,588)	Vari.	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (100,588)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (606,938)		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

SEE ACCOUNTANTS' COMPILATION REPORT

St Anthony's Nursing & Rehab Center

ID# 0047126

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salaries	\$ (37,679)	43	1
2	Labs - Part A	(6,130)	43	2
3	X-Rays - Part A	(5,065)	43	3
4	Penalties	(12,000)	43	4
5	Political Contributions	(584)	43	5
6	Other Services - Medicare	(1,239)	43	6
7	Offset Goodwill Amort.	(6,165)	31	7
8	PAC Dues	(724)	20	8
9	Misc Income Facility	(88)	21	9
10	Real Estate Entity Rental Income	(44,208)	32	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(113,882)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Anthony's Nursing & Rehab Center# 0047126 Report Period Beginning:01/01/2008Ending: 12/31/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	690	0	0	0	0	0	0	0	0	690	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	690	0	0	0	0	0	0	0	0	690	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	257	0	0	0	0	0	0	0	0	257	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	257	0	0	0	0	0	0	0	0	257	16
	C. General Administration													
17	Administrative	0	0	(98,575)	0	0	0	0	0	0	0	0	(98,575)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,216	(143,433)	0	0	0	0	0	0	0	0	(139,217)	19
20	Fees, Subscriptions & Promotions	(724)	0	1,155	0	0	0	0	0	0	0	0	431	20
21	Clerical & General Office Expenses	(88)	460	7,702	0	0	0	0	0	0	0	0	8,074	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	1,642	0	0	0	0	0	0	0	0	1,642	23
24	Travel and Seminar	0	0	11,456	0	0	0	0	0	0	0	0	11,456	24
25	Other Admin. Staff Transportation	0	0	1,127	0	0	0	0	0	0	0	0	1,127	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,412	0	0	0	0	0	0	0	0	1,412	26
27	Other (specify):*	0	0	44,707	0	0	0	0	0	0	0	0	44,707	27
28	TOTAL General Administration	(812)	4,676	(172,807)	0	0	0	0	0	0	0	0	(168,943)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(812)	4,676	(171,860)	0	0	0	0	0	0	0	0	(167,996)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(55,418)	111,605	1,513	0	0	0	0	0	0	0	0	57,700	30
31	Amortization of Pre-Op. & Org.	(6,165)	6,166	0	0	0	0	0	0	0	0	0	1	31
32	Interest	(44,242)	249,097	0	0	0	0	0	0	0	0	0	204,855	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)	8,072	0	0	0	0	0	0	0	0	(303,928)	34
35	Rent-Equipment & Vehicles	0	0	2,143	0	0	0	0	0	0	0	0	2,143	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(105,825)	54,868	11,728	0	(39,229)	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):*	(427,439)	0	0	0	0	0	0	0	0	0	0	(427,439)	43
44	TOTAL Special Cost Centers	(427,439)	0	0	0	0	0	0	0	0	0	0	(427,439)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(534,076)	59,544	(160,132)	0	(634,664)	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'sProperty Partners	100.00%	\$ 4,216	\$	4,216	1
2	V	20 Dues, Fees & Subscriptions		St. Anthony'sProperty Partners	100.00%				2
3	V	21 Clerical - Other		St. Anthony'sProperty Partners	100.00%	460		460	3
4	V	30 Depreciation		St. Anthony'sProperty Partners	100.00%	111,605		111,605	4
5	V	31 Amortization		St. Anthony'sProperty Partners	100.00%	6,166		6,166	5
6	V	32 Interest	33,072	St. Anthony'sProperty Partners	100.00%	282,169		249,097	6
7	V	34 Rent- Facility & Grounds	312,000	St. Anthony'sProperty 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		\$ 345,072			\$ 404,616	\$ *	59,544	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	SAK Management Services, LLC	90.00%	\$ 690	\$ 690
16	V	6 Maintenance		SAK Management Services, LLC	90.00%	0	16
17	V	10 Nursing - Salaries		SAK Management Services, LLC	90.00%	257	257
18	V	17 Administrative - Salaries	98,575	SAK Management Services, LLC	90.00%	0	(98,575)
19	V	19 Professional Fees	147,862	SAK Management Services, LLC	90.00%	4,429	(143,433)
20	V	20 Dues,Fees & Subs		SAK Management Services, LLC	90.00%	1,155	1,155
21	V	21 Clerical		SAK Management Services, LLC	90.00%	7,702	7,702
22	V	21 Clerical - Salaries		SAK Management Services, LLC	90.00%	0	22
23	V	23 Training/Education		SAK Management Services, LLC	90.00%	1,642	1,642
24	V	24 Travel/Seminar		SAK Management Services, LLC	90.00%	10,995	10,995
25	V	25 Other Admin. Transp		SAK Management Services, LLC	90.00%	1,127	1,127
26	V	26 Insurance - Prop/Liability		SAK Management Services, LLC	90.00%	1,412	1,412
27	V	27 EE Benefits		SAK Management Services, LLC	90.00%	44,707	44,707
28	V	30 Depreciation Expense		SAK Management Services, LLC	90.00%	1,513	1,513
29	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	90.00%	8,072	8,072
30	V	35 Rent - Eqpt. & Vehicles		SAK Management Services, LLC	90.00%	2,143	2,143
31	V	24 Travel & Seminar		SAK Management Services, LLC	90.00%	461	461
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 246,437			\$ 86,305	\$ * (160,132)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nursing & Rehab Center # 0047126 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												1
2	N/A											2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$			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: 01/01/2008 Ending: 2/31/2008

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 SAK Management Services
 Street Address 4055 W. Peterson, Suite 101
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 202-0000
 Fax Number (733) 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	1,915,081	8	\$ 5,361	\$ 246,437	\$ 690	1
2	6	Maintenance	SAK Management Fees	1,915,081	8	0	246,437	0	2
3	10	Nursing - Salaries	SAK Management Fees	1,915,081	8	1,998	246,437	257	3
4	17	Administrative - Salaries	SAK Management Fees	1,915,081	8	0	246,437	0	4
5	19	Professional Fees	SAK Management Fees	1,915,081	8	34,415	246,437	4,429	5
6	20	Dues,Fees & Subs	SAK Management Fees	1,915,081	8	8,974	246,437	1,155	6
7	21	Clerical	SAK Management Fees	1,915,081	8	59,856	246,437	7,702	7
8	21	Clerical - Salaries	SAK Management Fees	1,915,081	8	0	246,437	0	8
9	23	Training/Education	SAK Management Fees	1,915,081	8	12,762	246,437	1,642	9
10	24	Travel/Seminar	SAK Management Fees	1,915,081	8	85,442	246,437	10,995	10
11	25	Other Admin. Transp	SAK Management Fees	1,915,081	8	8,757	246,437	1,127	11
12	26	Insurance - Prop/Liability	SAK Management Fees	1,915,081	8	10,969	246,437	1,412	12
13	27	EE Benefits	SAK Management Fees	1,915,081	8	347,424	246,437	44,707	13
14	30	Depreciation Expense	SAK Management Fees	1,915,081	8	11,758	246,437	1,513	14
15	34	Rent - Facility & Grounds	SAK Management Fees	1,915,081	8	62,727	246,437	8,072	15
16	35	Rent - Eqpt. & Vehicles	SAK Management Fees	1,915,081	8	16,653	246,437	2,143	16
17	24	Travel & Seminar	Direct Cost			461		461	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 667,558	\$ 1,998	\$ 86,305	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **St Anthony's Nursing & Rehab Center** # **0047126** 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	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	5/19/05	\$ 3,850,000	\$ 3,850,000	05/2009	Prime +1	\$ 197,467	1								
2	United Leasing		X	Lease Payable				3,683				2								
3												3								
4												4								
5												5								
Working Capital																				
6	Cole Taylor Bank		X	Revolving Line of Credit	Varies	05/20/05		864,436	05/2009	Variable	43,761	6								
7	Monroe Capital		X	Line of Credit	Varies	05/19/05		433,222	05/19/09	0.0925	84,702	7								
8												8								
9	TOTAL Facility Related						\$ 3,850,000	\$ 5,151,341			\$ 325,930	9								
B. Non-Facility Related*																				
10												10								
11											Offset Interest Income	(44,208)	11							
12											Interest Income (Bldg Co.)	(33,072)	12							
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (77,280)	14								
15	TOTALS (line 9+line14)						\$ 3,850,000	\$ 5,151,341			\$ 248,650	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.)

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 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 #: (733) 267-0111

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>09-231-19-00</u>	<u>Long Term Care Property</u>	\$ <u>1,335.12</u>	\$ <u>1,335.12</u>
2. <u>09-175-06-00</u>	<u>Long Term Care Property</u>	\$ <u>70,458.12</u>	\$ <u>70,458.12</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>71,793.24</u>	\$ <u>71,793.24</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 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: 149,308 B. General Construction Type: Exterior Brick Frame Wood 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: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	319,300	2005	\$ 150,000	1
2					2
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	\$ 234,284	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Security & Monitoring System		2005		3,522	617	20	176	(441)	856	10
11	Boiler		2005		24,087	4,222	10	2,409	(1,813)	8,432	11
12	Boiler repairs		2008		18,233	2,604	7	1,302	(1,302)	1,302	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)	\$	2,095,842	\$	7,443	\$	62,458	\$	55,015	\$	244,874	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	\$ 3,334	\$ 31,913	\$ 28,579	10	\$ 127,779	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Management Co			1,513	1,513			74
75	TOTALS	\$ 311,806	\$ 3,334	\$ 33,426	\$ 30,092		\$ 127,779	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	\$ 906	76
77										77
78										78
79										79
80	TOTALS			\$ 1,506	\$	\$ 302	\$ 302		\$ 906	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)	\$ 2,559,154	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,777	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,186	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 85,409	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 373,559	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 519,778	92
93			93
94			94
95		\$ 519,778	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

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

0047126

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 Co.</u>			<u>8,072</u>			6
7	TOTAL			\$ <u>8,072</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: \$ 13,056 Description: Copier 3866, Postage Meter 4658, Nursing Equip 996, Mgmt Allocation 2143, Boiler 1393

(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. /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.

SEE ACCOUNTANTS' COMPILATION REPORT

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. 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			
	1	2	3	4
	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.)

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10A (2,3)	hrs	\$	2,227	\$ 133,624	\$ 33	2,227	\$ 133,657	1
2	Licensed Speech and Language Development Therapist	10A (3)	hrs		138	8,269		138	8,269	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (3)	hrs		2,908	174,503		2,908	174,503	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				160,611		160,611	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>	39 (2)					29,035		29,035	13
14	TOTAL			\$	5,273	\$ 316,396	\$ 189,679	5,273	\$ 506,075	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 St Anthony's Nursing & Rehab Center

0047126

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	\$ 33,948	\$ 40,614	1
2 Cash-Patient Deposits	172	172	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance (357,000))	1,305,909	1,645,344	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	95,334	95,334	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): See Sch 17A	21,348	87,267	9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,456,711	\$ 1,868,731	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		150,000	13
14 Buildings, at Historical Cost		2,050,000	14
15 Leasehold Improvements, at Historical Cos		45,842	15
16 Equipment, at Historical Cost	68,661	313,312	16
17 Accumulated Depreciation (book methods)	(32,205)	(373,559)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs		92,500	19
20 Accumulated Amortization - Organization & Pre-Operating Costs		(22,610)	20
21 Restricted Funds			21
22 Other Long-Term Assets (spec See Sch 17A		519,778	22
23 Other(specify): HUD Reserve		1,018,247	23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 36,456	\$ 3,793,510	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,493,167	\$ 5,662,241	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 1,134,250	\$ 1,363,708	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	864,436	864,436	29
30 Accrued Salaries Payable	182,472	182,472	30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)		24,849	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Se Sch 17A	708,820	125,135	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,889,978	\$ 2,560,600	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable		436,905	39
40 Mortgage Payable		3,850,000	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,286,905	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,889,978	\$ 6,847,505	46
47 TOTAL EQUITY (page 18, line 24)	\$ (1,396,811)	\$ (1,185,264)	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,493,167	\$ 5,662,241	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

St. Anthony's Nursing & Rehabilitation Center

Provider #: 0047126

1/1/2008 to 12/31/2008

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 9 - Other (specify)		
Real Estate Tax Escrow - C.T.	0	65,919
Iowa State Withholding	127	127
Due to Medicare	21,221	21,221
	<u>21,348</u>	<u>87,267</u>
Line 22 - Other Long Term Assets (specify)		
Construction Reserve - C.T.	0	5,688
Construction In Process	0	514,090
Total Line 22 - Other Long Term Assets	<u>0</u>	<u>519,778</u>
Line 36 - Other Current Liabilities (specify)		
Due from St. Anthony's Nursing & Rehab	0	(583,685)
Employee Loans, Adv., Wage Assignment	25	25
Due to St. Anthony's Property, LLC	583,685	583,685
Due to DPA	12,000	12,000
Due to Lessor/Prior Owner	90,938	90,938
Trust Account Liability	22,172	22,172
Total Line 36 - Other Current Liabilities	<u>708,820</u>	<u>125,135</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (603,813)	1
2	Restatements (describe):		2
3			3
4		(1,223)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (605,036)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(791,775)	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)	\$ (791,775)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,396,811)	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	\$ 3,988,178	1
2	Discounts and Allowances for all Levels	(32,363)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,955,815	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	777,743	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 777,743	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 Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	187,136	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,209	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,946	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 195,291	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17	26
E. Other Revenue (specify):***			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending / Misc Revenue	863	28
28a	Other outside services		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 863	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,929,729	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,157,295	31
32	Health Care	2,339,491	32
33	General Administration	1,081,716	33
B. Capital Expense			
34	Ownership	459,219	34
C. Ancillary Expense			
35	Special Cost Centers	617,084	35
36	Provider Participation Fee	66,699	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,721,504	40
41	Income before Income Taxes (line 30 minus line 40)**	(791,775)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (791,775)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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	1,816	1,983	\$ 57,171	\$ 28.83	1
2	Assistant Director of Nursing	1,960	2,096	45,238	21.58	2
3	Registered Nurses	7,524	7,659	173,030	22.59	3
4	Licensed Practical Nurses	26,108	28,360	520,072	18.34	4
5	CNAs & Orderlies	75,925	80,404	859,468	10.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,660	3,933	60,109	15.28	8
9	Activity Director					9
10	Activity Assistants	6,338	6,854	62,073	9.06	10
11	Social Service Workers	1,784	2,096	31,019	14.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,135	20,111	211,868	10.53	15
16	Dishwashers					16
17	Maintenance Workers	9,807	10,605	130,275	12.28	17
18	Housekeepers	11,753	12,865	118,994	9.25	18
19	Laundry	5,247	5,623	59,553	10.59	19
20	Administrator	2,008	2,176	81,497	37.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,601	6,032	84,622	14.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,792	3,072	77,224	25.14	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,627	1,692	19,163	11.33	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,176	2,351	37,679	16.03	33
34	TOTAL (lines 1 - 33)	184,261	197,912	\$ 2,629,055 *	\$ 13.28	34

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	\$ 5,458	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	10(3)	39
40	Physical Therapy Consultant	1	46	10A(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	660	11(3)	44
45	Social Service Consultant	Monthly	1,808	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1	\$ 34,372		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

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 Hufsy</u>	<u>Administrator</u>	<u>0</u>	\$ <u>81,497</u>	<u>Workers' Compensation Insurance</u>	\$ <u>106,238</u>	<u>IDPH License Fee</u>	\$ <u>995</u>		
				<u>Unemployment Compensation Insurance</u>	<u>35,685</u>	<u>Advertising: Employee Recruitment</u>	<u>786</u>		
				<u>FICA Taxes</u>	<u>195,186</u>	<u>Health Care Worker Background Check</u>	<u>7,750</u>		
				<u>Employee Health Insurance</u>	<u>81,341</u>	(Indicate # of checks performed <u>1430</u>)	<u>610</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>61</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>IL Council LTC</u>	<u>9,623</u>		
				<u>Employee Relations</u>	<u>3,883</u>	<u>Misc Dues Subscriptions</u>	<u>725</u>		
				<u>Other</u>	<u>191</u>	<u>Misc Licenses & Permits</u>	<u>4,685</u>		
						<u>Allocated from Management Co</u>	<u>1,155</u>		
						<u>Dues Offset</u>	<u>(724)</u>		
						<u>Less: Public Relations Expense</u>	<u>()</u>		
						<u>Non-allowable advertising</u>	<u>()</u>		
						<u>Yellow page advertising</u>	<u>()</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 81,497	TOTAL (agree to Schedule V, line 22, col.8)	\$ 422,524	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,605		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
<u>SAX Management Services, LLC-Management Fees</u>			\$ <u>98,575</u>				<u>Out-of-State Travel</u>	\$ <u> </u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 98,575				<u>In-State Travel</u>	<u> </u>	
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>3,334</u>	
C. Professional Services							<u>See attached Schedule</u>	<u> </u>	
Vendor/Payee	Type	Amount					<u>Allocated from Management Co</u>	<u>11,456</u>	
<u>Personnel Planners</u>	<u>Unemployment Consult</u>	\$ <u>1,110</u>					<u>Entertainment Expense</u>	<u>()</u>	
<u>Joseph Abramchik</u>	<u>Operation Consulting</u>	<u>17,400</u>					(agree to Sch. V, line 24, col. 8)		
<u>Alpha Data Services</u>	<u>Data Processing</u>	<u>790</u>					TOTAL	\$ 14,790	
<u>Emdeon Bus Services</u>	<u>Data Processing</u>	<u>28</u>							
<u>Health Data Systems</u>	<u>Data Processing</u>	<u>6,698</u>							
<u>Ivans Inc</u>	<u>Data Processing</u>	<u>2,253</u>							
<u>LTC Solutions</u>	<u>Data Processing</u>	<u>1,500</u>							
<u>Payday</u>	<u>Data Processing</u>	<u>3,648</u>							
<u>Aronberg Goldgehn Davis</u>	<u>Legal</u>	<u>476</u>							
<u>Shaw Gussis Fishman</u>	<u>Legal</u>	<u>3,791</u>							
<u>Frost Ruttenberg & Roth</u>	<u>Accounting</u>	<u>1,940</u>							
<u>SAK Management Services</u>	<u>Bookkeeping Services</u>	<u>147,862</u>							
TOTAL (agree to Schedule V, line 19, column 3)		\$ 187,496							
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

St. Anthony's Nursing & Rehab Center
Facility ID#: 0047126
Schedule XIX
12/31/2008

Schedule 21A

Schedule XIX (C) - Professional Fees.

TOTAL (agree to Schedule V, line 19, column 3)	187,496
Allocation from SAK - Legal	1,249
Allocation from SAK - Accounting	1,340
Allocation from SAK - Other Consulting	909
Allocation from SAK - Data Processing	929
Offset SAK Bookkeeping Fees	(147,862)
Allocation from Real Estate Entity	4,216
	<hr/>
TOTAL (agree to Schedule V, line 19, column 8)	<u><u>48,279</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	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A						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 St Anthony's Nursing & Rehab Center

0047126

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 -\$9623
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 19,003 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. \$ 66,699
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 benefit 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 program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients?
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 service 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