

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,984	1,930	4,169	16,083	8
9	SNF/PED					9
10	ICF	14,976	2,896		17,872	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,960	4,826	4,169	33,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.56%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 44 and days of care provided 3,600

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: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Antonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	210,761	13,100	7,037	230,898		230,898		230,898		1
2	Food Purchase		281,727		281,727		281,727		281,727		2
3	Housekeeping	135,233	37,650		172,883		172,883		172,883		3
4	Laundry	52,986	23,053		76,039		76,039		76,039		4
5	Heat and Other Utilities			233,663	233,663		233,663	(10,157)	223,506		5
6	Maintenance	104,747		109,353	214,100		214,100	2,941	217,041		6
7	Other (specify):* See Supplemental	38,963			38,963		38,963		38,963		7
8	TOTAL General Services	542,690	355,530	350,053	1,248,273		1,248,273	(7,216)	1,241,057		8
	B. Health Care and Programs										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	1,602,405	159,944	6,997	1,769,346		1,769,346	22,783	1,792,129		10
10a	Therapy										10a
11	Activities	63,105	521		63,626		63,626		63,626		11
12	Social Services	34,765		7,259	42,024		42,024		42,024		12
13	CNA Training										13
14	Program Transportation			14,742	14,742		14,742		14,742		14
15	Other (specify):* See Supplemental							3,284	3,284		15
16	TOTAL Health Care and Programs	1,700,275	160,465	50,598	1,911,338		1,911,338	26,067	1,937,405		16
	C. General Administration										
17	Administrative	83,813			83,813		83,813		83,813		17
18	Directors Fees										18
19	Professional Services			445,424	445,424		445,424	(351,932)	93,492		19
20	Dues, Fees, Subscriptions & Promotions			24,954	24,954		24,954	(4,304)	20,650		20
21	Clerical & General Office Expenses	90,846	3,395	68,222	162,463		162,463	41,029	203,492		21
22	Employee Benefits & Payroll Taxes			363,218	363,218		363,218		363,218		22
23	Inservice Training & Education										23
24	Travel and Seminar			335	335		335	2,126	2,461		24
25	Other Admin. Staff Transportation			10,204	10,204		10,204	551	10,755		25
26	Insurance-Prop.Liab.Malpractice			126,655	126,655		126,655	3,505	130,160		26
27	Other (specify):* See Supplemental							11,144	11,144		27
28	TOTAL General Administration	174,659	3,395	1,039,012	1,217,066		1,217,066	(297,881)	919,185		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,417,624	519,390	1,439,663	4,376,677		4,376,677	(279,030)	4,097,647		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.

**St Anthony's Nsg & Rehab Ctr
 Medicaid Cost Report
 01/01/13 - 12/31/13**

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	38,963		
Total	38,963	-	-
Line 15 Detailed			
Alloc. SAK Management Services, LLC - Emp. Ben.			3,284
Total	-	-	3,284
Line 27 Detailed			
Alloc. SAK Management Services, LLC - Emp. Ben.			11,144
Total	-	-	11,144

**St Antonys Nsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Payee	Amount	Allowable
Amy Buckwalter	802	
Judy Douglass	105	105
Leonard Koenig	667	
Loretta Price	6,497	6,497
Shannon Hauser	2,133	2,133
Alloc. SAK Management Services, LLC	2,020	2,020
	<u>12,224</u>	<u>10,755</u>

Facility Name & ID Number

St Antonys Nsg & Rehab Ctr

#0047126

Report Period Beginning:

01/01/13

Ending:

12/31/13

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			36,726	36,726		36,726	353,975	390,701			30
31	Amortization of Pre-Op. & Org.			15,750	15,750		15,750	(15,750)				31
32	Interest			72,405	72,405		72,405	757,520	829,925			32
33	Real Estate Taxes							78,500	78,500			33
34	Rent-Facility & Grounds			1,164,725	1,164,725		1,164,725	(1,156,486)	8,239			34
35	Rent-Equipment & Vehicles			2,044	2,044		2,044	1,248	3,292			35
36	Other (specify):* See Supplemental							68,136	68,136			36
37	TOTAL Ownership			1,291,650	1,291,650		1,291,650	87,143	1,378,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		352,293	726,486	1,078,779		1,078,779		1,078,779			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,989	243,989		243,989		243,989			42
43	Other (specify):* See Supplemental	56,417			56,417		56,417	(56,417)				43
44	TOTAL Special Cost Centers	56,417	352,293	970,475	1,379,185		1,379,185	(56,417)	1,322,768			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,474,041	871,683	3,701,788	7,047,512		7,047,512	(248,304)	6,799,208			45

*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

St Antonys Nsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
St. Anthony's Property Partners, LLC - Mort. Ins.			68,136
Total	-	-	68,136
Line 43 Detailed			
Marketing	56,417		
Total	56,417	-	-

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	(10,157)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(34,995)	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	(1,300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,905)	21		24
25	Fund Raising, Advertising and Promotional	(3,525)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(165,890)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (244,772)		\$	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)	(3,532)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,532)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (248,304)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

St Anthony's Nsg & Rehab Ctr

ID# 0047126

Report Period Beginning: 01/01/13

Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (9,428)	21	1
2	Marketing Salaires	(56,417)	43	2
3	Capitalized Assets < \$2,500	2,893	06	3
4	Other Income	(3,245)	21	4
5	Non-Allowable Legal	(46,510)	19	5
6	Non-Allowable Professional - Marketing	(2,654)	19	6
7	Marketing - Travel	(1,469)	25	7
8	Amortization	(15,750)	31	8
9				9
10				10
11				11
12	St. Anthony's Property Partners, LLP			12
13	Professional Fees	(2,073)	19	13
14	Office and Clerical	(500)	21	14
15	Amortization	(30,737)	31	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	(165,890)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Antonys Nsg & Rehab Ctr# 0047126

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,157)	0	0	0	0	0	0	0	0	0	0	(10,157)	5
6	Maintenance	2,893	0	48	0	0	0	0	0	0	0	0	2,941	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,264)	0	48	0	(7,216)	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	22,783	0	0	0	0	0	0	0	0	22,783	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	3,284	0	0	0	0	0	0	0	0	3,284	15
16	TOTAL Health Care and Programs	0	0	26,067	0	26,067	16							
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(51,237)	2,073	(302,768)	0	0	0	0	0	0	0	0	(351,932)	19
20	Fees, Subscriptions & Promotions	(4,825)	0	521	0	0	0	0	0	0	0	0	(4,304)	20
21	Clerical & General Office Expenses	(42,078)	500	82,607	0	0	0	0	0	0	0	0	41,029	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,126	0	0	0	0	0	0	0	0	2,126	24
25	Other Admin. Staff Transportation	(1,469)	0	2,020	0	0	0	0	0	0	0	0	551	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,505	0	0	0	0	0	0	0	0	3,505	26
27	Other (specify):*	0	0	11,144	0	0	0	0	0	0	0	0	11,144	27
28	TOTAL General Administration	(99,609)	2,573	(200,845)	0	(297,881)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,873)	2,573	(174,730)	0	(279,030)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Antonys Nsg & Rehab Ctr# 0047126

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	0	352,590	1,385	0	0	0	0	0	0	0	0	353,975	30
31	Amortization of Pre-Op. & Org.	(46,487)	30,737	0	0	0	0	0	0	0	0	0	(15,750)	31
32	Interest	(34,995)	792,038	477	0	0	0	0	0	0	0	0	757,520	32
33	Real Estate Taxes	0	78,500	0	0	0	0	0	0	0	0	0	78,500	33
34	Rent-Facility & Grounds	0	(1,164,725)	8,239	0	0	0	0	0	0	0	0	(1,156,486)	34
35	Rent-Equipment & Vehicles	0	0	1,248	0	0	0	0	0	0	0	0	1,248	35
36	Other (specify):*	0	68,136	0	0	0	0	0	0	0	0	0	68,136	36
37	TOTAL Ownership	(81,482)	157,276	11,349	0	87,143	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(56,417)	0	0	0	0	0	0	0	0	0	0	(56,417)	43
44	TOTAL Special Cost Centers	(56,417)	0	0	0	0	0	0	0	0	0	0	(56,417)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(244,772)	159,849	(163,381)	0	(248,304)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Suzanne Koenig	90.00%	Lena Living Center	Lena, Illinois	Lena Property		
Gary Weintraub	10.00%			Partners, LLC	Lena, Illinois	Bldg. Partnership
				St. Anthony's		
				Property, LLC	Rock Island, Illinois	Bldg. Partnership
				SAK Management	Northfield, Illinois	Mgmt. 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:	
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	34 Rent - Building	\$ 1,164,725	St. Anthony's Property Partners, LLC	100.00%	\$	\$ (1,164,725)	1
2	V	32 Interest	27,380	St. Anthony's Property Partners, LLC	100.00%		(27,380)	2
3	V	19 Professional Fees		St. Anthony's Property Partners, LLC	100.00%	2,073	2,073	3
4	V	21 Office and Clerical		St. Anthony's Property Partners, LLC	100.00%	500	500	4
5	V	36 Other		St. Anthony's Property Partners, LLC	100.00%	68,136	68,136	5
6	V	30 Depreciation		St. Anthony's Property Partners, LLC	100.00%	352,590	352,590	6
7	V	31 Amortization		St. Anthony's Property Partners, LLC	100.00%	30,737	30,737	7
8	V	32 Interest		St. Anthony's Property Partners, LLC	100.00%	819,418	819,418	8
9	V	33 Real Estate Taxes		St. Anthony's Property Partners, LLC	100.00%	78,500	78,500	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,192,105			\$ 1,351,954	\$ * 159,849	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	06 Maintenance	\$	SAK Management Services, LLC	100.00%	\$ 48	\$	48	15
16	V	10 Nursing		SAK Management Services, LLC	100.00%	22,783		22,783	16
17	V	15 Employee Benefits		SAK Management Services, LLC	100.00%	3,284		3,284	17
18	V	19 Professional Fees	317,910	SAK Management Services, LLC	100.00%	15,142		(302,768)	18
19	V	20 Dues and Subscriptions		SAK Management Services, LLC	100.00%	521		521	19
20	V	21 Office and Clerical		SAK Management Services, LLC	100.00%	82,607		82,607	20
21	V	24 Seminar and Travel		SAK Management Services, LLC	100.00%	2,126		2,126	21
22	V	25 Other Staff Admin. Travel		SAK Management Services, LLC	100.00%	2,020		2,020	22
23	V	26 Insurance		SAK Management Services, LLC	100.00%	3,505		3,505	23
24	V	27 Employee Benefits		SAK Management Services, LLC	100.00%	11,144		11,144	24
25	V	30 Depreciation		SAK Management Services, LLC	100.00%	1,385		1,385	25
26	V	32 Interest		SAK Management Services, LLC	100.00%	477		477	26
27	V	34 Rent - Building		SAK Management Services, LLC	100.00%	8,239		8,239	27
28	V	35 Rent - Equipment		SAK Management Services, LLC	100.00%	1,248		1,248	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 317,910			\$ 154,529	\$ *	(163,381)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthony's Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	N/A								\$	1
2										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 Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 SAK Management Services, LLC
 Street Address 1 Northfield Plaza, Suite 480
 City / State / Zip Code Northfield, Illinois 60093
 Phone Number (847) 446 - 8400
 Fax Number (847) 446 - 8432

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	06	Maintenance	SAK Consulting Fees	2,088,811		\$ 316	\$ 317,910	\$ 48	1	
2	10	Nursing	SAK Consulting Fees	2,088,811		149,696	149,696	317,910	22,783	2
3	15	Employee Benefits	SAK Consulting Fees	2,088,811		21,578	317,910	3,284	3	
4	19	Professional Fees	SAK Consulting Fees	2,088,811		99,491	317,910	15,142	4	
5	20	Dues and Subscriptions	SAK Consulting Fees	2,088,811		3,425	317,910	521	5	
6	21	Office and Clerical	SAK Consulting Fees	2,088,811		542,766	503,122	317,910	82,607	6
7	24	Seminar and Travel	SAK Consulting Fees	2,088,811		13,966	317,910	2,126	7	
8	25	Other Staff Admin. Travel	SAK Consulting Fees	2,088,811		13,272	317,910	2,020	8	
9	26	Insurance	SAK Consulting Fees	2,088,811		23,027	317,910	3,505	9	
10	27	Employee Benefits	SAK Consulting Fees	2,088,811		73,223	317,910	11,144	10	
11	30	Depreciation	SAK Consulting Fees	2,088,811		9,102	317,910	1,385	11	
12	32	Interest	SAK Consulting Fees	2,088,811		3,132	317,910	477	12	
13	34	Rent - Building	SAK Consulting Fees	2,088,811		54,132	317,910	8,239	13	
14	35	Rent - Equipment	SAK Consulting Fees	2,088,811		8,197	317,910	1,248	14	
15									15	
16									16	
17									17	
18	19	Professional Fees	Direct	52,106		52,106			18	
19	25	Other Staff Admin. Travel	Direct	126,617		126,617			19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,194,046	\$ 652,818	\$ 154,529	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Antonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	HUD		X	Mortgage		12/17/09	\$ 11,995,400	\$ 11,823,825	12/18/47	6.7500	\$ 819,418	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Alloc. - SAK Mgmt Services	X		Working Capital							477	6								
7	Cole Taylor Bank		X	Line of Credit							18,654	7								
8	Bank Leumi		X	Line of Credit				475,000			28,114	8								
9	TOTAL Facility Related						\$ 11,995,400	\$ 12,298,825			\$ 866,663	9								
B. Non-Facility Related*																				
10	Monroe Capital		X	Working Capital							25,637	10								
11												11								
12	Interest Income		X								(34,995)	12								
13	Interest Income - Bldg. Part.		X								(27,380)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (36,738)	14								
15	TOTALS (line 9+line14)						\$ 11,995,400	\$ 12,298,825			\$ 829,925	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 68,136 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 2012 report.		\$	<u>89,949</u>	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.)		\$	<u>83,397</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(6,552)</u>	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>85,052</u>	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.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>78,500</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2008	<u>76,109</u>	8
	2009	<u>75,291</u>	9
	2010	<u>83,429</u>	10
	2011	<u>87,094</u>	11
	2012	<u>83,397</u>	12

FOR BHF USE ONLY

	13	FROM R. E. TAX STATEMENT FOR 2012	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

2013 Real Estate Tax Accrual = \$83,397 * 1.02 = \$85,052

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Antonys Nsg & Rehab Ctr COUNTY Rock Island
 FACILITY IDPH LICENSE NUMBER 0047126
 CONTACT PERSON REGARDING THIS REPORT Edward N. Slack
 TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-231-19-00</u>	<u>Long Term Care Facility</u>	\$ <u>1,407.52</u>	\$ <u>1,407.52</u>
2. <u>09-430-04-00</u>	<u>Long Term Care Facility</u>	\$ <u>74,862.48</u>	\$ <u>74,862.48</u>
3. <u>09-430-05-00</u>	<u>Long Term Care Facility</u>	\$ <u>7,126.92</u>	\$ <u>7,126.92</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>83,396.92</u></u>	\$ <u><u>83,396.92</u></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 and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

01/01/13 Ending:

12/31/13

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).

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>319,300</u>	<u>2005</u>	<u>\$ 155,000</u>	1
2					2
3	TOTALS	319,300		\$ 155,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	130		2005	1974	\$ 2,050,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2005		27,609						9
10	Various		2008		18,233						10
11	Various		2009		4,635						11
12	Boiler Repairs		2010		22,384						12
13	New Water Heater		2011		7,920						13
14	Drain Repairs		2011		3,108						14
15	Oxygen Fill System Cylinders & Cart		2011		2,669						15
16	Broken Steam Line Repairs		2011		4,195						16
17	Water Heater		2013		16,698						17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26	St. Anthony's Property Partners, LLC										26
27											27
28	Complete Facility Rehabilitation and Renovation		2012		6,510,694						28
29	Complete Facility Rehabilitation and Renovation		2013		82,851						29
30											30
31											31
32											32
33											33
34	Depreciation - St. Anthony's Nursing & Rehab Center, LLC					36,726		36,726		162,584	34
35	Depreciation - St. Anthony's Property Partners, LLC					352,590		352,590		1,449,576	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)

C. Equipment Costs-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	\$ 350,401	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Supplemental	783,235	1,385	1,385			15,682	74
75	TOTALS	\$ 1,133,636	\$ 1,385	\$ 1,385	\$		\$ 15,682	75

D. Vehicle Costs. (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 Windstar	2005	\$ 1,506	\$	\$	\$		\$	76
77	Facility	Snow Plow Truck	2010	5,500						77
78										78
79										79
80	TOTALS			\$ 7,006	\$	\$	\$		\$	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)	\$ 10,046,638	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 390,701	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 390,701	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,627,842	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		\$	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

**St Anthony's Nsg & Rehab Ctr
 Medicaid Cost Report
 01/01/13 - 12/31/13**

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - St. Anthony's Property Partners, LLC			
Prior	765,300		
Current			
Total	765,300	-	-
Related Party 2 - SAK Management Services, LLC			
Prior	14,555	258	14,555
Current	3,380	1,127	1,127
Total	17,935	1,385	15,682
Related Party 3 -			
Prior			
Current			
Total	-	-	-
Related Party 4 -			
Prior			
Current			
Total	-	-	-
Total	783,235	1,385	15,682

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party
 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	See							5
6	Supplement				8,239			6
7	TOTAL				\$ 8,239			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: \$ 3,292 Description: See Supplemental Schedule
 (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					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. | <u>/2014</u> | \$ _____ |
| 13. | <u>/2015</u> | \$ _____ |
| 14. | <u>/2016</u> | \$ _____ |

* If there is an option to buy the building, please provide complete details on attached schedule.
 ** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13

Page 14 Supplemental Schedule - Building and Fixed Equipment

<u>Vendor</u>	<u>Amount</u>
Alloc. - SAK Management Services, LLC	8,239
Total	<u><u>8,239</u></u>

Page 14 Supplemental Schedule - Equipment Rental

<u>Vendor</u>	<u>Amount</u>
MI - KO Enterprises	2,044
Alloc. - SAK Management Services, LLC	1,248
Total	<u><u>3,292</u></u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	288,599	\$		\$	288,599	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				51,494				51,494	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				382,644				382,644	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					265,033			265,033	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						87,260			87,260	12
13	Other (specify): See Supplemental	39 - 03					3,749				3,749	13
14	TOTAL			\$		\$	726,486	\$	352,293	\$	1,078,779	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

St Antonys Nsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13

Page 16 Supplemental Schedule

<u>Description</u>	<u>Supplies</u>	<u>Other</u>
Medical Supplies	77,242	
Therapy Supplies	10,018	
Laboratory and Radiology		388
Other Services		3,361
Total	<u>87,260</u>	<u>3,749</u>

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning: 01/01/13

Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 50,905	\$ 69,164	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>603,124</u>)	1,403,354	1,403,354	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,440	10,440	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>		86,751	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,464,699	\$ 1,569,709	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,000	13
14	Buildings, at Historical Cost		8,643,545	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	232,243	997,543	16
17	Accumulated Depreciation (book methods)	(162,584)	(1,612,160)	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):			22
23	Other(specify): <u>See Supplemental Schedule</u>		629,301	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,659	\$ 8,813,229	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,534,358	\$ 10,382,938	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,319,249	\$ 3,407,600	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	475,000	475,000	29
30	Accrued Salaries Payable	153,960	153,960	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		85,052	32
33	Accrued Interest Payable		199,403	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	346,652		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,294,861	\$ 4,321,015	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,823,825	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,823,825	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,294,861	\$ 16,144,840	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,760,503)	\$ (5,761,902)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,534,358	\$ 10,382,938	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Due from Related Parties		86,751
Total	-	86,751
Line 23 - Other Long Term Assets		
Replacement Reserve Escrow		102,619
Property Tax Escrow		13,449
Insurance Escrow		31,163
Construction Reserve Escrow		668
Goodwill (Net of Amortization)		39,074
Loan Issuance Costs		442,328
Total	-	629,301
Line 36 - Other Current Liabilities		
Due to Related Parties	346,652	
Total	346,652	-
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,147,158)	1
2	Restatements (describe):		2
3	Prior Year Rent Expense - JE Post Medicaid CR	2,411,334	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,735,824)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,024,679)	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)	\$ (1,024,679)	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)	\$ (2,760,503)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,667,868	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,667,868	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	314,500	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 314,500	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	513	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 513	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	34,995	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,995	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,957	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,957	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,022,833	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,248,273	31
32	Health Care	1,911,338	32
33	General Administration	1,217,066	33
B. Capital Expense			
34	Ownership	1,291,650	34
C. Ancillary Expense			
35	Special Cost Centers	1,135,196	35
36	Provider Participation Fee	243,989	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,047,512	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,024,679)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,024,679)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,304,834	44
45	Private Pay - Net Inpatient Revenue	694,378	45
46	Medicare - Net Inpatient Revenue	1,575,547	46
47	Other-(specify) Hospice - Net Inpatient Revenue		47
48	Other-(specify) Insurance - Net Inpatient Revenue	93,109	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,667,868	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? [Not Finished](#) 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,920	2,080	\$ 60,695	\$ 29.18	1
2	Assistant Director of Nursing	1,810	2,074	46,856	22.59	2
3	Registered Nurses	10,032	10,622	253,020	23.82	3
4	Licensed Practical Nurses	24,710	26,375	474,678	18.00	4
5	CNAs & Orderlies	68,500	72,537	767,156	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,335	5,839	63,105	10.81	10
11	Social Service Workers	2,072	2,128	34,765	16.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,599	21,880	210,761	9.63	15
16	Dishwashers					16
17	Maintenance Workers	7,409	8,038	104,747	13.03	17
18	Housekeepers	14,961	15,871	135,233	8.52	18
19	Laundry	5,318	5,824	52,986	9.10	19
20	Administrator	1,940	2,100	83,813	39.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,036	6,552	90,846	13.87	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) <u>Security/Mrking</u>	6,195	6,668	95,380	14.30	33
34	TOTAL (lines 1 - 33)	176,837	188,588	\$ 2,474,041 *	\$ 13.12	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	\$ 7,037	01 - 03	35
36	Medical Director	21,600	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,997	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	7,259	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 42,893		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			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	
David Taylor	Administrator	0	\$ 53,482	Workers' Compensation Insurance	\$ 136,567	IDPH License Fee	\$	
Gina Graham	Administrator	0	30,331	Unemployment Compensation Insurance	19,060	Advertising: Employee Recruitment		
				FICA Taxes	180,198	Health Care Worker Background Check		
				Employee Health Insurance	22,971	(Indicate # of checks performed)	2,840	
				Employee Meals		Patient Background Checks	2,000	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	13,806	
				Employee Physicals	227	Licenses	1,483	
				Other Employee Welfare	4,195	Advertising and Promotion	3,525	
						Alloc. SAK Management Services, LLC	521	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 83,813					
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 363,218	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	(3,525)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(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
SAK Management Services, LLC	Management Fees		\$ 0			\$	Out-of-State Travel	\$
Polsinelli Shughart, P.C.	Legal		33,763					
SNR Denton US, LLP	Legal		19,667					
Aronberg, Goldengehn, Davis	Legal		690				In-State Travel	
Law Office of Stephen N. Sher	Legal		21,845					
Cohn Reznick, LLP	Accounting		7,075					
Sharon Haugh Lofgren	Accounting		3,700					
McGladrey, LLP	Accounting		10,898				Seminar Expense	335
Proliant	Data Processing		4,509				Alloc. SAK Management Services, LLC	2,126
HDSI	Data Processing		6,828					
Emdeon Business	Data Processing		423					
See Supplemental Schedule			18,117				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 127,514	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,461

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Other	Data Processing	2,899
Healthcare Investigators	Business Development	324
Kay Wallin	Marketing Consultant	2,331
Midwest Renovation and Restoration, Inc.	Renovation Consulting	3,839
Pharmacy Price Management	Operational Consulting	1,250
Richard Peelo & Associates	Accounting	4,200
LTC Solutions	Data Processing	1,500
Personnel Planners	Unemployment Consultant	1,775

Total

18,117

**St Anthony's Nsg & Rehab Ctr
 Medicaid Cost Report
 01/01/13 - 12/31/13**

Page 21 Supplemental Schedule - Legal Details

Vendor	Invoice Date	Amount	Allowable
Polsinelli Shughart, P.C.	01/23/13	1,186	
Aronberg, Goldengehn, Davis	02/13/13	270	
Aronberg, Goldengehn, Davis	02/15/13	270	
SNR Denton US, LLP	02/19/13	19,575	
Aronberg, Goldengehn, Davis	02/19/13	150	
Law Office of Stephen N. Sher	02/19/13	21,845	
Polsinelli Shughart, P.C.	02/28/13	4,756	4,756
Polsinelli Shughart, P.C.	03/28/13	1,134	1,134
Polsinelli Shughart, P.C.	04/22/13	1,612	1,612
Polsinelli Shughart, P.C.	05/23/13	2,499	2,499
Polsinelli Shughart, P.C.	06/30/13	2,658	2,658
SNR Denton US, LLP	07/01/13	3,215	
Polsinelli Shughart, P.C.	07/19/13	3,215	3,215
Polsinelli Shughart, P.C.	08/31/13	4,606	4,606
Polsinelli Shughart, P.C.	09/26/13	3,048	3,048
Polsinelli Shughart, P.C.	10/25/13	2,772	2,772
Polsinelli Shughart, P.C.	11/22/13	2,951	2,951
Polsinelli Shughart, P.C.	12/31/13	3,328	3,328
Total		<u><u>79,088</u></u>	<u><u>32,577</u></u>
Non-Allowable			<u><u>46,510</u></u>

**St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 21 Supplemental Schedule - Seminar

Vendor	Invoice Date	Amount	Allowable
Illinois Health Care Association	09/18/13	335	335
Alloc. - SAK Management Services, LLC		2,126	2,126
Total		<u>2,461</u>	<u>2,461</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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

01/01/13

Ending: 12/31/13

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. ICLTC = \$13,806
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,020 Line 10 - 02
- (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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 243,989
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. \$ 0 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? Ln. 14
- d. Have vehicle usage logs been maintained? Yes
- 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
- (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