Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Management Co.	100.00%	$ 144	$ 144	15
16	V	3	Housekeeping		SW Management Co.	100.00%	83	83	16
17	V	5	Heat and Other Utilities		SW Management Co.	100.00%	1,254	1,254	17
18	V	6	Maintenance		SW Management Co.	100.00%	535	535	18
19	V	17	Administrative	120,000	SW Management Co.	100.00%	47,843	(72,157)	19
20	V	19	Professional Services		SW Management Co.	100.00%	1,791	1,791	20
21	V	20	Dues,Fees,Subs & Promotions		SW Management Co.	100.00%	88	88	21
22	V	21	Clerical & General Office Expense		SW Management Co.	100.00%	44,252	44,252	22
23	V	24	Travel and Seminar		SW Management Co.	100.00%	44	44	23
24	V	25	Other Admin. Staff Transport		SW Management Co.	100.00%	972	972	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	453	453	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,944	12,944	26
27	V	30	Depreciation		SW Management Co.	100.00%	2,501	2,501	27
28	V	32	Interest		SW Management Co.	100.00%	57	57	28
29	V	33	Real Estate Taxes		SW Management Co.	100.00%	2,694	2,694	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.	100.00%	918	918	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			$ 120,000			$ 116,573	$ * (3,427)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 19,969	S & E Medical Supply Co.	100.00%	$ 12,844	$ (7,125)	15
16	V	3	Housekeeping	2,194	S & E Medical Supply Co.	100.00%	2,194		16
17	V	10	Medical Supplies	4,972	S & E Medical Supply Co.	100.00%	9,453	4,481	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$ 27,135			$ 24,491	$ * (2,644)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.14	Salary	$ 14,071	L17, C7	1
2	Ronnie Klein	COO	Administrative	4.99	See Schedule 7B	5	10.00	Salary&Fees	19,700	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	7.14	Salary	14,071	L17, C7	3
4											4
5											5
6											6
7											7
8		All individuals work in excess of 40 hours per week.									8
9											9
10											10
11											11
12											12
13								TOTAL	$ 47,842		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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: SW Management Co.
Street Address: 7434 N. Skokie Blvd
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	742,930	12	$ 1,959	$	54,750	$ 144	1
2	3	Housekeeping	Bed Days Available	742,930	12	1,125		54,750	83	2
3	5	Heat and Other Utilities	Bed Days Available	742,930	12	17,016		54,750	1,254	3
4	6	Maintenance	Bed Days Available	742,930	12	7,264		54,750	535	4
5	19	Professional Services	Bed Days Available	742,930	12	24,293		54,750	1,791	5
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	742,930	12	1,198		54,750	88	6
7	21	Clerical & General Office Exp	Bed Days Available	742,930	12	600,468	509,094	54,750	44,252	7
8	24	Travel and Seminar	Bed Days Available	742,930	12	594		54,750	44	8
9	25	Other Admin. Staff Transport	Bed Days Available	742,930	12	13,194		54,750	972	9
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	742,930	12	6,148		54,750	453	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	742,930	12	175,644		54,750	12,944	11
12	32	Interest	Bed Days Available	742,930	12	778		54,750	57	12
13	33	Real Estate Taxes	Bed Days Available	742,930	12	36,555		54,750	2,694	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	742,930	12	12,454		54,750	918	14
15										15
16										16
17	17	Administrative	Avg Hours Worked	84	12	394,000	394,000	6	28,143	17
18		Administrative	Avg Hours Worked	50	6	197,000	197,000	5	19,700	18
19										19
20	30	Depreciation	Direct Cost	33,940					2,501	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,489,691	$ 1,100,094		$ 116,573	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 12,844	1
2	3	Housekeeping	Direct Cost						2,194	2
3	10	Medical Supplies	Direct Cost						9,453	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					$	$		$ 24,491	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Heartland Bank		X	Mortgage	$23,524.00	11/27/01	$ 3,961,000	$ 3,588,826	12/1/36	0.0635	$ 229,577	1
2												2
3								Amortization of Mortgage Costs			4,312	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$23,524.00		$ 3,961,000	$ 3,588,826			$ 233,889	9
	B. Non-Facility Related*											
10							Allocated from Mgmt Co.				57	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 57	14
15	TOTALS (line 9+line14)						$ 3,961,000	$ 3,588,826			$ 233,946	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 18,066 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.)

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center **#** 0039636 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 151,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2009**	$ 127,070	2
3. Under or (over) accrual (line 2 minus line 1).		$ (23,930)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 131,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	**Mgmt Alloc.**	$ 365	5
	Allocated from Management Co.	2,329	
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.		$ 109,764	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	177,414	8
	2006	179,854	9
	2007	201,159	10
	2008	146,260	11
	2009	127,070	12

2010 Tax Accrual = 127,070 X 1.03 = 130,882. Use 131,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cahokia Nursing & Rehabilitation Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039636

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-02.0-310-055	Long Term Care Property	$ 124,091.08	$ 124,091.08
2.	06-02.0-310-054	Long Term Care Property	$ 2,978.70	$ 2,978.70
3.	10-28-412-049-0000	SW Management Allocation	$ 33,634.00	$ 2,329.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 160,703.78	$ 129,398.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2001	$ 230,000	1
2	Office Space for Employees		2006	15,000	2
3	TOTALS			$ 245,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2001		$ 2,928,441	$	15-40	$ 68,691	$ 68,691	$ 716,248	4
5			2006		55,818	2,030	40	1,431	(599)	6,441	5
6											6
7	Allocated from Management Co.		1995		31,898		39	911	911	14,267	7
8											8
	Improvement Type**										
9	Various			1994	17,859	268	20	523	255	15,933	9
10	Various			1995	33,623	337	20	1,681	1,344	26,455	10
11	Various			1996	2,178	56	20	109	53	1,598	11
12	Various			1997	9,423		20	471	471	6,363	12
13	Various			1998	4,800	123	20	240	117	3,000	13
14	Various			1999	16,266	93	20	813	720	9,538	14
15	Air Handler			2000	1,516		5			1,516	15
16	Alarm System			2001	1,908		5			1,908	16
17	Blind			2001	1,212		5			1,212	17
18	Air Handler			2001	1,317		20	66	66	626	18
19	Fan Motor			2001	1,123		20	56	56	510	19
20	Drywall-Dining Room			2002	10,650	184	10	1,065	881	9,408	20
21	Door			2002	9,860	184	20	493	309	3,985	21
22	Air Conditioner			2002	1,198		7			1,198	22
23	Air Conditioner			2002	1,582		7			1,582	23
24	Air Conditioners			2002	4,284		7			4,284	24
25	Compressor Air Maxi			2002	1,269		7			1,269	25
26	Roof - New			2003	97,996	2,513	20	4,900	2,387	37,974	26
27	Nursing Station			2003	35,060		20	1,753	1,753	12,855	27
28	Nursing Station			2003	28,692		20	1,435	1,435	11,717	28
29	Nursing Station			2003	6,368		20	318	318	2,255	29
30	Replace Accelerator			2003	968		20	48	48	386	30
31	Sprinkler System			2004	3,610	131	20	181	50	1,174	31
32	Smoke shelter			2004	6,041	220	20	302	82	1,963	32
33	Security System			2005	11,166	406	20	558	152	3,070	33
34	Condensing Unit - 5 Ton			2005	1,959	71	20	98	27	539	34
35	Cabinets and countertops			2005	110,923	4,011	20	5,546	1,535	30,504	35
36	Air Handler			2005	1,549	56	20	78	22	427	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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Asphalt Parking Lot	2005	$ 5,570	$ 347	20	$ 279	$ (69)	$ 1,532	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	301	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	1,155	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	1,208	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	402	41
42	Door Alarms	2005	3,587	130	20	179	49	986	42
43	Wallpaper	2005	17,835		20	892	892	4,905	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	8,140	44
45	6 Doors	2005	1,926	70	20	96	26	529	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	2,858	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	1,342	47
48	Duct Heater	2006	1,195	43	20	60	17	269	48
49	Kitchen Garbage Disposal	2006	1,467	169	20	73	(96)	330	49
50	Copper Pipe & Concrete	2006	3,722	135	20	186	51	837	50
51	Fence	2006	6,061	420	20	303	(117)	1,364	51
52	Shower Remodel - Hall 400	2006	21,570	784	20	1,079	295	4,854	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	2,194	53
54	Shower Remodel - Hall 200	2006	21,570	784	20	1,079	295	4,854	54
55	Shower Remodel - Hall 500	2006	21,570	784	20	1,079	295	4,854	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	4,405	56
57	Front Entrance	2006	2,150	78	20	108	30	484	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	756	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	389	59
60	Compressor-Walk In Freezer	2006	1,784	65	20	89	24	401	60
61	Air Conditioners (5)	2006	2,146	247	10	215	(32)	966	61
62	Air Conditioners (6)	2006	2,576	297	20	129	(168)	580	62
63	Phone System	2006	1,658	191	20	83	(108)	373	63
64	Remove & reinstall 6 dry pendents	2007	3,039	111	20	152	41	532	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	1,313	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	158	43	553	66
67	New Window Glass	2007	3,562	130	20	178	48	623	67
68	Paving, Parking Lot & Driveway	2007	32,275	2,483	20	1,614	(869)	5,648	68
69	Handrails	2007	2,980		20	149	149	522	69
70	TOTAL (lines 4 thru 69)		$ 3,699,894	$ 20,392		$ 104,841	$ 84,449	$ 990,662	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,699,894	$ 20,392		$ 104,841	$ 84,449	$ 990,662	1
2	Fire Damper and Roof Vent	2007	5,114	186	20	256	70	895	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790		20	440	440	1,539	3
4	Walk In Freezer Door	2007	2,316	84	20	116	32	406	4
5	Replace 4 Inch Main	2008	3,158	115	20	158	43	395	5
6	Sprinkler heads for alarm	2008	29,310	1,066	20	1,466	400	3,664	6
7	Sign	2008	2,685		20	134	134	335	7
8	Hot Water Heater	2009	5,182	188	20	259	71	389	8
9	Vinyl Flooring	2009	14,512	528	20	726	198	1,089	9
10	Hot Water Heater	2009	5,094	185	20	255	70	382	10
11	Valves	2010	3,310	65	20	83	18	83	11
12	Flooring	2010	17,827		20	446	446	446	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	Allocated from SW Management - Leasehold Improvements	1995	3,570		20	178	178	3,037	21
22	Allocated from SW Management - Leasehold Improvements	1996	594		20	30	30	433	22
23	Allocated from SW Management - Leasehold Improvements	1997	689		20	34	34	550	23
24	Allocated from SW Management - Leasehold Improvements	1998	589		20	29	29	376	24
25	Allocated from SW Management - Leasehold Improvements	1999	1,636		20	82	82	907	25
26	Allocated from SW Management - Leasehold Improvements	2005	3,384		20	169	169	931	26
27	Allocated from SW Management - Leasehold Improvements	2007	1,916		20	96	96	335	27
28	Allocated from SW Management - Leasehold Improvements	2009	4,000		20	200	200	300	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,813,570	$ 22,809		$ 109,996	$ 87,187	$ 1,007,154	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 780,535	$ 2,242	$ 16,693	$ 14,451	10	$ 524,830	71
72	Current Year Purchases	16,080	16,080	804	(15,276)	10	804	72
73	Fully Depreciated Assets	165,016					165,016	73
74	Allocated from Management Co.	10,072		204	204	10	7,790	74
75	TOTALS	$ 971,703	$ 18,322	$ 17,701	$ (621)		$ 698,440	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	Allocated from Management	2010 Infiniti	2010	$ 5,667	$	$ 567	$ 567	5	$ 567	76
77										77
78										78
79										79
80	TOTALS			$ 5,667	$	$ 567	$ 567		$ 567	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)	$ 5,035,940	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,131	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,264	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 87,133	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,706,161	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ N/A Description: N/A
(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	Allocated from Management Co.		$	$ 918	17
18					18
19					19
20					20
21	TOTAL		$	$ 918	21

* 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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,927	$ 210,742	$	2,927	$ 210,742	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,577	75,692		1,577	75,692	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,751	176,088		2,751	176,088	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				89,622		89,622	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	7,255	$ 462,522	$ 89,622	7,255	$ 552,144	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

STATE OF ILLINOIS

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 1,000	$ 1,000	1
2	Cash-Patient Deposits	41,049	41,049	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance - 0 -)	491,964	491,964	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,936	32,828	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	462,727	739,076	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,010,676	$ 1,305,917	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	3,016,157	14
15	Leasehold Improvements, at Historical Cost	644,005	797,413	15
16	Equipment, at Historical Cost	478,759	977,370	16
17	Accumulated Depreciation (book methods)	(672,869)	(1,706,161)	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 (spe See Schedule 17A		112,316	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 520,713	$ 3,442,095	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,531,389	$ 4,748,012	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (362,306)	$ (420,050)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,329	46,329	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,882	81,882	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,246	10,246	31
32	Accrued Real Estate Taxes(Sch.IX-B)		131,000	32
33	Accrued Interest Payable		18,991	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	731,479	233,754	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 507,630	$ 102,152	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,588,826	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,588,826	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 507,630	$ 3,690,978	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,023,759	$ 1,057,034	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,531,389	$ 4,748,012	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Cahokia Nursing & Rehabilitation Center, Inc.
Provider #: 0039636
12/31/2010
Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve	-	168,893
RE Escrow Real Estate Tax	-	107,456
Reimbursement Due	106,688	106,688
Short Term Loan Exchange	356,039	356,039
Total Line 9-Other Current Assets (Specify)	462,727	739,076

Other Long-Term Assets (Specify)		
RE Capitalized Costs	-	150,935
RE Accumulated Amortization	-	(38,619)
Total Line 22-Other Long-Term Assets (specify)	-	112,316

Other Current Liabilities (Specify)		
Insurance Premiums Payable	750	750
Acc. Retirement (From P/R)	600	600
Accrued Expenses	177,777	177,777
Due to Public Aid	-	-
Due/From Cahokia Property LLC	538,179	40,454
Due/From Vacant Cahokia Property	14,173	14,173
Total Line 36-Other Current Liabilities (Specify)	731,479	233,754

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 718,943	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 718,943	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	304,818	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(2)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 304,816	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)**	$ 1,023,759	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,523,148	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,523,148	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	463,375	6
7	Oxygen	6,535	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 469,910	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,548	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,548	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustment	6,414	28
28a	Veterans Refund	19,943	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,357	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,031,963	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,157,195	31
32	Health Care	2,429,190	32
33	General Administration	1,384,091	33
	B. Capital Expense		
34	Ownership	550,049	34
	C. Ancillary Expense		
35	Special Cost Centers	124,494	35
36	Provider Participation Fee	82,126	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,727,145	40
41	**Income before Income Taxes (line 30 minus line 40)****	304,818	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 304,818	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 66,327	$ 31.89	1
2	Assistant Director of Nursing	768	968	27,513	28.42	2
3	Registered Nurses	2,091	2,263	58,165	25.71	3
4	Licensed Practical Nurses	26,562	28,411	602,315	21.20	4
5	CNAs & Orderlies	81,917	87,364	901,597	10.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,054	7,865	101,747	12.94	8
9	Activity Director					9
10	Activity Assistants	5,702	6,195	69,375	11.20	10
11	Social Service Workers	3,613	3,943	50,939	12.92	11
12	Dietician					12
13	Food Service Supervisor	1,731	1,881	29,134	15.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,270	20,904	199,220	9.53	15
16	Dishwashers					16
17	Maintenance Workers	3,801	4,160	56,451	13.57	17
18	Housekeepers	18,819	20,643	172,799	8.37	18
19	Laundry	11,445	12,168	106,769	8.77	19
20	Administrator	3,896	4,160	214,588	51.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,859	15,966	344,538	21.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,487	218,969	$ 3,001,477 *	$ 13.71	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,090	L1, C3	35
36	Medical Director	Monthly	3,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,471	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	4,654	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	428	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,643		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Teresa Ruberg	Administrator	0	$ 72,000
Robin Suydam	Administrator	0	142,588
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 214,588

B. Administrative - Other

Description	Amount
SW Management-Management Fees	$ 120,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ashman & Stein	Legal	$ 354
Hepler Broom McDonald Hebrank	Legal	17,377
Stone McGuire Siegel	Legal	673
Gallop, Johnson & Neuman	Peer Review	92
Stephen N. Sher	Legal	6,651
McGladrey & Pullen, LLP	Accounting	15,718
Honkamp Krueger & Co	Accounting	56
Field & Goldberg	Legal	607
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 41,528

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 155,847
Unemployment Compensation Insurance	35,392
FICA Taxes	227,407
Employee Health Insurance	42,794
Employee Meals	4,961
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	5,557
TOTAL (agree to Schedule V, line 22, col.8)	$ 471,958

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 171)	2,050
Patient Background Checks	
Illinois Council on Long Term Care	15,000
Miscellaneous Dues & Permits	4,308
Miscellaneous Inspections & Licenses	3,089
Allocated from Management Co.	88
See Schedule 21A	(2,986)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,549

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,364
Allocated from Management Co.	44
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,408

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center, Inc.
Provider # : 0039636
12/31/2010 Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	41,528
Nonallowable Legal Fees	(2,172)
Allocated from Real Estate Entity - Legal	4,000
Allocated from Real Estate Entity - Accounting	7,750
Allocated from Mangement Company - Legal	793
Allocated from Mangement Company - Accounting	998
Total (Agree to Schedule V, Line 19, Column 8)	52,897

F. Dues, Fees, Subscriptions and Promotions

Total (From Page 21 Section F.)	24,535
Allocated from RE Entity	492
Less: Non-Allowable Lobbying Expense	(3,478)
Total (Agree to Schedule V, Line 20, Column 8)	21,549

SEE ACCOUNTANTS' COMPILATION REPORT

Provider Number - 0039636
Schedule of Travel and Seminar Detail

Modify cross references as needed.

Not necessary to complete if total is less than $2,000.

Section XIX Continued:

Persons Attending	Title	Date Attended	Location	Title Sponsor	Cost
Nora	Food Service Sanitation Course	February 10 & 17, 2010	East St. Louis, IL	East Side Health District	100.00
Teresa Roberg & Amy Suydam	Skills Training for Psychiatric Rehab.	April 8, 2010	Springfield	Illinois Council on Long Term Care	280.00
Teresa Roberg, Linda Stuckey & Vicki Cooper	Accident and Fall Prevention Strategies	February 25, 2010	Springfield	Illinois Health Care Association	285.00
Teresa Roberg, Linda Stuckey & Amy Suydam	The New Enforcement Spotlight on Subpart S	April 22, 2010	Springfield	Illinois Council on Long Term Care	330.00
Veronica Thomas	Skills Training for Psychiatric Rehab.	April 8, 2010	Springfield	Illinois Council on Long Term Care	140.00
Teresa Roberg, Cheryl Pratt, Vivki Cooper, Erica Williams, Keena Johnson-Tomlinson	MDS 3.0: Getting Started	June 25, 2010	Fairview Heights	Illinois Health Care Association	825.00
Jeffrey Davis	MDS 3.0: Getting Started	June 25, 2010	Fairview Heights	Illinois Health Care Association	165.00
Amy Suydam	Skills Training	May 22, 2010	Cahokia, IL	Atrium	75.00
Robin Suydam, Cheryl Pratt, Diana Powell, Amy Suydam, Donita Dobbleair, Erica Williams, Linda Stuck	MDS 3.0: Getting Started	August 25, 2010	Mt. Vernon	Life Services Network	770.00
Teresa Roberg, Robin Suydam, Linda Stuckey, Sandy Mentola	Long Term Care - Directors of Nursing Conf.	October 13, 2010	Fairview Heights	Long Term Care - D.O.N.	200.00
Diana Powell	IL Activity Professionals Assoc. Conference	October 28 & 29, 2010	Rockford	Illinois Activity Professionals Assoc.	200.00
Teresa Roberg	Implications of the MDS 3.0	October 22, 2010	Webinar	American College of Health Care Admins.	39.00
Teresa Roberg	MDS 3.0: Section by Section	October 22, 2010	Webinar	Illinois Health Care Association	375.00
Teresa Roberg	IL Nursing Home Admin's Assoc. Conference	November 2 & 3, 2010	Springfield	IL Nursing Home Administrator's Assoc.	225.00
Teresa Roberg	28th Annual Hospice Conference	November 9, 2010	Edwardsville	Southern Illinois University, Edwardsville	70.00
Teresa Roberg	Medicare & Scheduling; Coding MDS 3.0	October 7, 14 & 28, 2010	Webinar	MLN	285.00
Allocated from Management Co.					44.00
TOTAL					4,408.00

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
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 Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. **Illinois Council on Long Term Care-$15,000**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **229** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,126**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **4,961** 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? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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.