FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0039636

Facility Name: Cahokia Nursing & Rehabilitation Center, Inc.

Address: 2 Annabelle Court (Number) Cahokia (City) 62206 (Zip Code)

County: St. Clair

Telephone Number: (618) 332-0114 **Fax #** (618) 332-1043

HFS ID Number:

Date of Initial License for Current Owners: 06/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' PREPARATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,825	285	4,445	8,555	8
9	SNF/PED					9
10	ICF	27,646	3,023	418	31,087	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,471	3,308	4,863	39,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.41%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/94

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 2,569

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, In # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	237,867	20,766	6,204	264,837		264,837		264,837			1
2	Food Purchase		289,427		289,427		289,427	(30,973)	258,454			2
3	Housekeeping	153,149	87,191		240,340		240,340	112	240,452			3
4	Laundry	96,521	8,390		104,911		104,911		104,911			4
5	Heat and Other Utilities			136,457	136,457		136,457	1,430	137,887			5
6	Maintenance	57,963	57,190	16,324	131,477		131,477	562	132,039			6
7	Other (specify):*											7
8	TOTAL General Services	545,500	462,964	158,985	1,167,449		1,167,449	(28,869)	1,138,580			8
	B. Health Care and Programs											
9	Medical Director			3,250	3,250		3,250		3,250			9
10	Nursing and Medical Records	1,763,133	78,913	3,793	1,845,839		1,845,839	20,416	1,866,255			10
10a	Therapy			474,227	474,227		474,227		474,227			10a
11	Activities	72,006	9,569	158	81,733		81,733		81,733			11
12	Social Services	51,330			51,330		51,330		51,330			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,886,469	88,482	481,428	2,456,379		2,456,379	20,416	2,476,795			16
	C. General Administration											
17	Administrative	218,753		120,000	338,753		338,753	(88,583)	250,170			17
18	Directors Fees											18
19	Professional Services			80,323	80,323		80,323	2,463	82,786			19
20	Dues, Fees, Subscriptions & Promotions			6,468	6,468		6,468	(3,140)	3,328			20
21	Clerical & General Office Expenses	428,237		54,829	483,066		483,066	56,986	540,052			21
22	Employee Benefits & Payroll Taxes			389,607	389,607		389,607	6,033	395,640			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,146	2,146		2,146	(167)	1,979			24
25	Other Admin. Staff Transportation			8,318	8,318		8,318	2,230	10,548			25
26	Insurance-Prop.Liab.Malpractice			177,686	177,686		177,686	4,460	182,146			26
27	Other (specify):* Mgmt Alloc of Benefit							17,745	17,745			27
28	TOTAL General Administration	646,990		839,377	1,486,367		1,486,367	(1,973)	1,484,394			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,078,959	551,446	1,479,790	5,110,195		5,110,195	(10,426)	5,099,769			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. #0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,846	38,846		38,846	93,159	132,005			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							313,685	313,685			32
33	Real Estate Taxes							123,895	123,895			33
34	Rent-Facility & Grounds			504,000	504,000		504,000	(504,000)				34
35	Rent-Equipment & Vehicles							1,105	1,105			35
36	Other (specify):* Mortgage Insurance							37,596	37,596			36
37	TOTAL Ownership			542,846	542,846		542,846	65,440	608,286			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,050		123,050		123,050		123,050			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Non-Allow Costs			35,701	35,701		35,701	(35,701)				43
44	TOTAL Special Cost Centers		123,050	117,826	240,876		240,876	(35,701)	205,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,078,959	674,496	2,140,462	5,893,917		5,893,917	19,313	5,913,230			45

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,443)	30		9
10	Interest and Other Investment Income	297	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(272)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,231)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,635)	43		24
25	Fund Raising, Advertising and Promotional	(42)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,000)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(20,927)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,503)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)	82,816		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 82,816		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 19,313		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Cahokia Nursing & Rehabilitation Center, Inc.

ID# 0039636

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (10,489)	43	1
2	X Ray Expense Med A	(4,013)	43	2
3	Out of Period Education & Seminar	(190)	24	3
4	Disallow lobbying expense	(3,685)	20	4
5	Chamber of Commerce	(100)	24	5
6	Unreconciled real estate tax	(2,450)	33	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,927)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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)	
1	V	19	Professional Services	$	Cahokia Building LLC	100.00%	$ 7,329	$ 7,329	1
2	V	20	Dues Fees Subscriptions		Cahokia Building LLC	100.00%	524	524	2
3	V	26	Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	4,054	4,054	3
4	V	30	Depreciation		Cahokia Building LLC	100.00%	104,904	104,904	4
5	V	32	Interest Income	297	Cahokia Building LLC	100.00%		(297)	5
6	V	32	Interest		Cahokia Building LLC	100.00%	200,268	200,268	6
7	V	33	Real Estate Tax		Cahokia Building LLC	100.00%	122,794	122,794	7
8	V	34	Rent	504,000	Cahokia Building LLC	100.00%		(504,000)	8
9	V	36	Mortgage Insurance		Cahokia Building LLC	100.00%	37,596	37,596	9
10	V	32	Amortization		Cahokia Building LLC	100.00%	1,460	1,460	10
11	V	30	Loan fees				111,957	111,957	11
12	V								12
13	V								13
14	Total			$ 504,297			$ 590,886	$ * 86,589	14

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Abraham J Stern	4.67	Cahokia Nursing and Rehab	Cahokia	Shabbona Supportive I	Shabbona	Supportive Living F	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	S.W. Management Co.	Skokie	Bookkeeping/Manag	2
3	Sheldon Wolfe	23.67	Shabbona Healthcare Center	Shabbona	S&E Medical Supply C	Skokie	Medical Supplies	3
4	Ronnie Klein as Trustee	4.99			* SFO Associates	Skokie	Finance Company	4
5	Maurice Aaron	4.67						5
6	Michael Klein Revocable Trust	1.99	Rosewood Health & Rehab	Independence, MO	* This entity only relates to Shabbona Healthcare Center,			6
7	Wanda Bowling	0.67	Beauvais Manor Healthcare and Rehab	St. Louis, Mo	Franklin Grove Living and Rehab, and Oregon Living			7
8	Miriam Y Klein as Trustee	6.67	Hillside Manor Healthcare and Rehab	St. Louis, MO	and Rehab			8
9	Michael A Klein as Trustee	6.67	Rancho Manor Healthcare and Rehab	Florissant, MO				9
10	Kenneth Klein	4.99						10
11	Susan Stern	4.67						11
12	Jonathan B Stern 2001 Trust	1.56						12
13	Todd A. Stern 2001 Trust	1.56						13
14	Evan M. Stern	1.56						14
15	Moshe Herman	0.67						15
16	Ora Aaron	4.67						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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (January-February)	100.00%	$ 26	$ 26	15
16	V	3	Housekeeping		SW Management Co. (January-February)	100.00%	15	15	16
17	V	5	Heat and Other Utilities		SW Management Co. (January-February)	100.00%	194	194	17
18	V	6	Maintenance		SW Management Co. (January-February)	100.00%	76	76	18
19	V	17	Administrative	20,000	SW Management Co. (January-February)	100.00%	4,834	(15,166)	19
20	V	19	Professional Services		SW Management Co. (January-February)	100.00%	185	185	20
21	V	20	Dues,Fees,Subs & Promotions		SW Management Co. (January-February)	100.00%	16	16	21
22	V	21	Clerical & General Office Expense		SW Management Co. (January-February)	100.00%	6,782	6,782	22
23	V	24	Travel and Seminar		SW Management Co. (January-February)	100.00%	3	3	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (January-February)	100.00%	302	302	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (January-February)	100.00%	55	55	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (January-February)	100.00%	2,405	2,405	26
27	V	30	Depreciation		SW Management Co. (January-February)	100.00%	616	616	27
28	V	32	Interest		SW Management Co. (January-February)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (January-February)	100.00%	481	481	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (January-February)	100.00%	150	150	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			$ 20,000			$ 16,140	$ * (3,860)	39

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (March)	100.00%	$ 15	$ 15	15
16	V	3	Housekeeping		SW Management Co. (March)	100.00%	9	9	16
17	V	5	Heat and Other Utilities		SW Management Co. (March)	100.00%	114	114	17
18	V	6	Maintenance		SW Management Co. (March)	100.00%	45	45	18
19	V	17	Administrative	10,000	SW Management Co. (March)	100.00%	2,900	(7,100)	19
20	V	19	Professional Services		SW Management Co. (March)	100.00%	109	109	20
21	V	20	Dues,Fees,Subs & Promotions		SW Management Co. (March)	100.00%	10	10	21
22	V	21	Clerical & General Office Expense		SW Management Co. (March)	100.00%	4,638	4,638	22
23	V	24	Travel and Seminar		SW Management Co. (March)	100.00%	2	2	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (March)	100.00%	178	178	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (March)	100.00%	32	32	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (March)	100.00%	1,417	1,417	26
27	V	30	Depreciation		SW Management Co. (March)	100.00%	308	308	27
28	V	32	Interest		SW Management Co. (March)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (March)	100.00%	284	284	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (March)	100.00%	88	88	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			$ 10,000			$ 10,149	$ * 149	39

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (April thru June)	100.00%	$ 49	$ 49	15
16	V	3	Housekeeping		SW Management Co. (April thru June)	100.00%	29	29	16
17	V	5	Heat and Other Utilities		SW Management Co. (April thru June)	100.00%	374	374	17
18	V	6	Maintenance		SW Management Co. (April thru June)	100.00%	147	147	18
19	V	17	Administrative	30,000	SW Management Co. (April thru June)	100.00%	10,150	(19,850)	19
20	V	19	Professional Services		SW Management Co. (April thru June)	100.00%	357	357	20
21	V	20	Dues,Fees,Subs & Promotions		SW Management Co. (April thru June)	100.00%	32	32	21
22	V	21	Clerical & General Office Expense		SW Management Co. (April thru June)	100.00%	15,188	15,188	22
23	V	24	Travel and Seminar		SW Management Co. (April thru June)	100.00%	6	6	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (April thru June)	100.00%	583	583	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (April thru June)	100.00%	106	106	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (April thru June)	100.00%	4,641	4,641	26
27	V	30	Depreciation		SW Management Co. (April thru June)	100.00%	925	925	27
28	V	32	Interest		SW Management Co. (April thru June)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (April thru June)	100.00%	929	929	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (April thru June)	100.00%	289	289	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			$ 30,000			$ 33,805	$ * 3,805	39

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (July-August)	100.00%	$ 33	$ 33	15
16	V	3	Housekeeping		SW Management Co. (July-August)	100.00%	20	20	16
17	V	5	Heat and Other Utilities		SW Management Co. (July-August)	100.00%	249	249	17
18	V	6	Maintenance		SW Management Co. (July-August)	100.00%	98	98	18
19	V	17	Administrative	20,000	SW Management Co. (July-August)	100.00%	6,766	(13,234)	19
20	V	19	Professional Services		SW Management Co. (July-August)	100.00%	238	238	20
21	V	20	Dues,Fees,Subs & Promotions		SW Management Co. (July-August)	100.00%	21	21	21
22	V	21	Clerical & General Office Expense		SW Management Co. (July-August)	100.00%	10,126	10,126	22
23	V	24	Travel and Seminar		SW Management Co. (July-August)	100.00%	4	4	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (July-August)	100.00%	389	389	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (July-August)	100.00%	71	71	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (July-August)	100.00%	3,094	3,094	26
27	V	30	Depreciation		SW Management Co. (July-August)	100.00%	616	616	27
28	V	32	Interest		SW Management Co. (July-August)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (July-August)	100.00%	619	619	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (July-August)	100.00%	193	193	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			$ 20,000			$ 22,537	$ * 2,537	39

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (September thru December)	100.00%	$ 66	$ 66	15
16	V	3	Housekeeping		SW Management Co. (September thru December)	100.00%	39	39	16
17	V	5	Heat and Other Utilities		SW Management Co. (September thru December)	100.00%	499	499	17
18	V	6	Maintenance		SW Management Co. (September thru December)	100.00%	196	196	18
19	V	17	Administrative	40,000	SW Management Co. (September thru December)	100.00%	6,767	(33,233)	19
20	V	19	Professional Services		SW Management Co. (September thru December)	100.00%	476	476	20
21	V	20	Dues,Fees,Subs & Promotions		SW Management Co. (September thru December)	100.00%	42	42	21
22	V	21	Clerical & General Office Expense		SW Management Co. (September thru December)	100.00%	20,252	20,252	22
23	V	24	Travel and Seminar		SW Management Co. (September thru December)	100.00%	8	8	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (September thru December)	100.00%	778	778	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (September thru December)	100.00%	142	142	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (September thru December)	100.00%	6,188	6,188	26
27	V	30	Depreciation		SW Management Co. (September thru December)	100.00%	1,233	1,233	27
28	V	32	Interest		SW Management Co. (September thru December)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (September thru December)	100.00%	1,238	1,238	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (September thru December)	100.00%	385	385	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			$ 40,000			$ 38,309	$ * (1,691)	39

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 49,960	S & E Medical Supply Co.	100.00%	$ 24,831	$ (25,129)	15
16	V	10	Medical Supplies	1,024	S & E Medical Supply Co.	100.00%	21,440	20,416	16
17	V								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			$ 50,984			$ 46,271	$ * (4,713)	39

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, I # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 14,500	L17, C7	1
2	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	7.14	Salary	14,500	L17, C7	2
3											3
4											4
5											5
6			Note: All individuals work in excess of 40 hours per week.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 29,000		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, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (January-February)
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	124,018	12	$ 358	$	8,850	$ 26	1
2	3	Housekeeping	Bed Days Available	124,018	12	213		8,850	15	2
3	5	Heat and Other Utilities	Bed Days Available	124,018	12	2,716		8,850	194	3
4	6	Maintenance	Bed Days Available	124,018	12	1,066		8,850	76	4
5	19	Professional Services	Bed Days Available	124,018	12	2,591		8,850	185	5
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	124,018	12	229		8,850	16	6
7	21	Clerical & General Office Exp	Bed Days Available	124,018	12	95,042	95,042	8,850	6,782	7
8	24	Travel and Seminar	Bed Days Available	124,018	12	42		8,850	3	8
9	25	Other Admin. Staff Transport	Bed Days Available	124,018	12	4,236		8,850	302	9
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	124,018	12	772		8,850	55	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	124,018	12	33,703		8,850	2,405	11
12	32	Interest	Bed Days Available	124,018	12			8,850	0	12
13	33	Real Estate Taxes	Bed Days Available	124,018	12	6,744		8,850	481	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	124,018	12	2,099		8,850	150	14
15										15
16										16
17	17	Administrative	Avg Hours Worked	42	12	33,833		3	2,417	17
18	17	Administrative	Avg Hours Worked	42	12	33,833		3	2,417	18
19	17	Administrative	Avg Hours Worked	40	3	33,833		0	0	19
20										20
21	30	Depreciation	Direct Cost	6,938					616	21
22										22
23										23
24										24
25	TOTALS					$ 251,310	$ 95,042		$ 16,140	25

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (March)
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	55,304	11	$ 179	$	4,650	$ 15	1
2	3	Housekeeping	Bed Days Available	55,304	11	106		4,650	9	2
3	5	Heat and Other Utilities	Bed Days Available	55,304	11	1,358		4,650	114	3
4	6	Maintenance	Bed Days Available	55,304	11	532		4,650	45	4
5	19	Professional Services	Bed Days Available	55,304	11	1,294		4,650	109	5
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	55,304	11	115		4,650	10	6
7	21	Clerical & General Office Exp	Bed Days Available	55,304	11	55,153	47,522	4,650	4,638	7
8	24	Travel and Seminar	Bed Days Available	55,304	11	22		4,650	2	8
9	25	Other Admin. Staff Transport	Bed Days Available	55,304	11	2,118		4,650	178	9
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	55,304	11	386		4,650	32	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	55,304	11	16,851		4,650	1,417	11
12	32	Interest	Bed Days Available	55,304	11			4,650		12
13	33	Real Estate Taxes	Bed Days Available	55,304	11	3,372		4,650	284	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	55,304	11	1,050		4,650	88	14
15										15
16										16
17	17	Administrative	Avg Hours Worked	35	11	16,917	16,917	3	1,450	17
18	17	Administrative	Avg Hours Worked	35	11	16,917	16,917	3	1,450	18
19	17	Administrative	Avg Hours Worked	40	3	16,917	16,917			19
20										20
21	30	Depreciation	Direct Cost	3,469					308	21
22										22
23										23
24										24
25	TOTALS					$ 133,287	$ 98,273		$ 10,149	25

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (April thru June)
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	148,694	10	$ 537	$	13,650	$ 49	1
2	3	Housekeeping	Bed Days Available	148,694	10	320		13,650	29	2
3	5	Heat and Other Utilities	Bed Days Available	148,694	10	4,074		13,650	374	3
4	6	Maintenance	Bed Days Available	148,694	10	1,599		13,650	147	4
5	19	Professional Services	Bed Days Available	148,694	10	3,886		13,650	357	5
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	148,694	10	344		13,650	32	6
7	21	Clerical & General Office Exp	Bed Days Available	148,694	10	165,455		13,650	15,188	7
8	24	Travel and Seminar	Bed Days Available	148,694	10	64		13,650	6	8
9	25	Other Admin. Staff Transport	Bed Days Available	148,694	10	6,354		13,650	583	9
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	148,694	10	1,158		13,650	106	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	148,694	10	50,553		13,650	4,641	11
12	32	Interest	Bed Days Available	148,694	10			13,650		12
13	33	Real Estate Taxes	Bed Days Available	148,694	10	10,116		13,650	929	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	148,694	10	3,149		13,650	289	14
15										15
16										16
17	17	Administrative	Avg Hours Worked	30	10	50,750	50,750	3	5,075	17
18	17	Administrative	Avg Hours Worked	30	10	50,750	50,750	3	5,075	18
19	17	Administrative	Avg Hours Worked	40	3	50,750	50,750			19
20										20
21	30	Depreciation	Direct Cost	10,408					925	21
22										22
23										23
24										24
25	TOTALS					$ 399,859	$ 152,250		$ 33,805	25

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (July-August)
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	101,308	10	$ 358	$	9,300	$ 33	1
2	3	Housekeeping	Bed Days Available	101,308	10	213		9,300	20	2
3	5	Heat and Other Utilities	Bed Days Available	101,308	10	2,716		9,300	249	3
4	6	Maintenance	Bed Days Available	101,308	10	1,066		9,300	98	4
5	19	Professional Services	Bed Days Available	101,308	10	2,591		9,300	238	5
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	101,308	10	229		9,300	21	6
7	21	Clerical & General Office Exp	Bed Days Available	101,308	10	110,303	95,042	9,300	10,126	7
8	24	Travel and Seminar	Bed Days Available	101,308	10	42		9,300	4	8
9	25	Other Admin. Staff Transport	Bed Days Available	101,308	10	4,236		9,300	389	9
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	101,308	10	772		9,300	71	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	101,308	10	33,703		9,300	3,094	11
12	32	Interest	Bed Days Available	101,308	10			9,300		12
13	33	Real Estate Taxes	Bed Days Available	101,308	10	6,744		9,300	619	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	101,308	10	2,099		9,300	193	14
15										15
16										16
17	17	Administrative	Avg Hours Worked	30	10	33,833	33,833	3	3,383	17
18	17	Administrative	Avg Hours Worked	30	10	33,833	33,833	3	3,383	18
19	17	Administrative	Avg Hours Worked	40	3	33,833	33,833			19
20										20
21	30	Depreciation	Direct Cost	6,938					616	21
22										22
23										23
24										24
25	TOTALS					$ 266,571	$ 196,541		$ 22,537	25

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (September thru December
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	199,348	10	$ 716	$	18,300	$ 66	1
2	3	Housekeeping	Bed Days Available	199,348	10	426		18,300	39	2
3	5	Heat and Other Utilities	Bed Days Available	199,348	10	5,432		18,300	499	3
4	6	Maintenance	Bed Days Available	199,348	10	2,131		18,300	196	4
5	19	Professional Services	Bed Days Available	199,348	10	5,181		18,300	476	5
6	20	Dues,Fees,Subs & Promotions	Bed Days Available	199,348	10	458		18,300	42	6
7	21	Clerical & General Office Exp	Bed Days Available	199,348	10	220,606	190,085	18,300	20,252	7
8	24	Travel and Seminar	Bed Days Available	199,348	10	86		18,300	8	8
9	25	Other Admin. Staff Transport	Bed Days Available	199,348	10	8,472		18,300	778	9
10	26	Insurance-Prop.Liab.&Malp.	Bed Days Available	199,348	10	1,543		18,300	142	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	199,348	10	67,405		18,300	6,188	11
12	32	Interest	Bed Days Available	199,348	10			18,300		12
13	33	Real Estate Taxes	Bed Days Available	199,348	10	13,488		18,300	1,238	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	199,348	10	4,198		18,300	385	14
15										15
16										16
17	17	Administrative	Avg Hours Worked	30	10	67,667	67,667	3	6,767	17
18	17	Administrative	Avg Hours Worked	30	10			3		18
19	17	Administrative	Avg Hours Worked	15	1	67,667	67,667			19
20										20
21	30	Depreciation	Direct Cost	13,877					1,233	21
22										22
23										23
24										24
25	TOTALS					$ 465,476	$ 325,419		$ 38,309	25

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 24,831	1
2	10	Medical Supplies	Direct Cost						21,440	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					$	$		$ 46,271	25

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 3,916,809	12/1/36	0.0635	$ 200,268	1
2												2
3								Amortization of Mortgage Costs			1,460	3
4												4
5												5
	Working Capital											
6							750,000	750,000				6
7												7
8												8
9	TOTAL Facility Related				$23,524.00		$ 4,711,000	$ 4,666,809			$ 201,728	9
	B. Non-Facility Related*											
10												10
11								Allocated from RE Entity - Loan Fees			111,957	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 111,957	14
15	TOTALS (line 9+line14)						$ 4,711,000	$ 4,666,809			$ 313,685	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 37,596 **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.)**

**** 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, Inc. # 0039636 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 131,000	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.)	**2010**	$ 122,091	2
3. Under or (over) accrual (line 2 minus line 1).		$ (8,909)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 128,772	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. Allocated from Management Co.**	$ 662	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ 3,370	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 123,895	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	179,854	8
2007	201,159	9
2008	146,260	10
2009	127,070	11
2010	122,091	12

2011 Tax Accrual = 122,091 * 1.0545 = 128,745. Use 128,772

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cahokia Nursing & Rehabilitation Center, Inc. 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 2010 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 2010.

	(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	$ 122,091.00	$ 122,091.00
2.	06-02.0-310-054	Long Term Care Property	$	$
3.	10-28-412-049-0000	SW Management Allocation	$ 33,410.00	$ 3,370.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 155,501.00	$ 125,461.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 784,939	4
5			2006		55,818	2,030	40	1,431	(599)	7,872	5
6											6
7	Allocated from Management Co.		1995		38,454		39	1,099	1,099	18,229	7
8											8
	Improvement Type**										
9	Various			1994	17,859		20	523	523	16,456	9
10	Various			1995	33,623	337	20	1,681	1,344	28,136	10
11	Various			1996	2,178	56	20	109	53	1,707	11
12	Various			1997	9,423		20	471	471	6,834	12
13	Various			1998	4,800	123	20	240	117	3,240	13
14	Various			1999	16,266	93	20	813	720	10,351	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	692	18
19	Fan Motor			2001	1,123		20	56	56	566	19
20	Drywall-Dining Room			2002	10,650	184	10	1,065	881	10,473	20
21	Door			2002	9,860	184	20	493	309	4,478	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	42,874	26
27	Nursing Station			2003	35,060		20	1,753	1,753	14,608	27
28	Nursing Station			2003	28,692		20	1,435	1,435	13,151	28
29	Nursing Station			2003	6,368		20	318	318	2,574	29
30	Replace Accelerator			2003	968		20	48	48	435	30
31	Sprinkler System			2004	3,610	131	20	181	50	1,354	31
32	Smoke shelter			2004	6,041	220	20	302	82	2,265	32
33	Security System			2005	11,166	406	20	558	152	3,628	33
34	Condensing Unit - 5 Ton			2005	1,959	71	20	98	27	637	34
35	Cabinets and countertops			2005	110,923	4,011	20	5,546	1,535	36,050	35
36	Air Handler			2005	1,549	56	20	78	22	504	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, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	$ 1,811	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	355	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	1,365	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	1,427	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	475	41
42	Door Alarms	2005	3,587	130	20	179	49	1,165	42
43	Wallpaper	2005	17,835		20	892	892	5,797	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	9,620	44
45	6 Doors	2005	1,926	70	20	96	26	626	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	3,378	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	1,585	47
48	Duct Heater	2006	1,195	43	20	60	17	329	48
49	Kitchen Garbage Disposal	2006	1,467	169	20	73	(96)	403	49
50	Copper Pipe & Concrete	2006	3,722	135	20	186	51	1,023	50
51	Fence	2006	6,061	420	20	303	(117)	1,667	51
52	Shower Remodel - Hall 400	2006	21,570	784	20	1,079	295	5,932	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	2,682	53
54	Shower Remodel - Hall 200	2006	21,570	784	20	1,079	295	5,932	54
55	Shower Remodel - Hall 500	2006	21,570	784	20	1,079	295	5,932	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	5,384	56
57	Front Entrance	2006	2,150	78	20	108	30	592	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	924	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	475	59
60	Compressor-Walk In Freezer	2006	1,784	65	20	89	24	490	60
61	Air Conditioners (5)	2006	2,146	247	10	215	(32)	1,181	61
62	Air Conditioners (6)	2006	2,576	297	20	129	(168)	709	62
63	Phone System	2006	1,658	191	20	83	(108)	456	63
64	Remove & reinstall 6 dry pendents	2007	3,039	111	20	152	41	684	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	1,688	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	158	43	711	66
67	New Window Glass	2007	3,562	130	20	178	48	801	67
68	Paving, Parking Lot & Driveway	2007	32,275	2,483	20	1,614	(869)	7,262	68
69	Handrails	2007	2,980		20	149	149	671	69
70	TOTAL (lines 4 thru 69)		$ 3,706,450	$ 20,124		$ 105,029	$ 84,905	$ 1,098,554	70

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,706,450	$ 20,124		$ 105,029	$ 84,905	$ 1,098,554	1
2	Fire Damper and Roof Vent	2007	5,114	186	20	256	70	1,151	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790		20	440	440	1,978	3
4	Walk In Freezer Door	2007	2,316	84	20	116	32	521	4
5	Replace 4 Inch Main	2008	3,158	115	20	158	43	553	5
6	Sprinkler heads for alarm	2008	29,310	1,066	20	1,466	400	5,130	6
7	Sign	2008	2,685		20	134	134	470	7
8	Hot Water Heater	2009	5,182	188	20	259	71	648	8
9	Vinyl Flooring	2009	14,512	528	20	726	198	1,815	9
10	Hot Water Heater	2009	5,094	185	20	255	70	637	10
11	Valves	2010	3,310	65	20	166	101	248	11
12	100 gallon hot water heater	2011	33,232		20	831	831	831	12
13	Security system - Phase 1 & 2	2011	21,394		20	535	535	535	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Allocated from SW Management - Leasehold Improvements	1995	4,304		20	215	215	3,876	26
27	Allocated from SW Management - Leasehold Improvements	1996	717		20	36	36	558	27
28	Allocated from SW Management - Leasehold Improvements	1997	831		20	42	42	705	28
29	Allocated from SW Management - Leasehold Improvements	1998	710		20	36	36	488	29
30	Allocated from SW Management - Leasehold Improvements	1999	1,972		20	99	99	1,192	30
31	Allocated from SW Management - Leasehold Improvements	2005	4,080		20	204	204	1,326	31
32	Allocated from SW Management - Leasehold Improvements	2007	2,310		20	115	115	520	32
33	Allocated from SW Management - Leasehold Improvements	2009	4,822		20	241	241	603	33
34	TOTAL (lines 1 thru 33)		$ 3,860,293	$ 22,541		$ 111,357	$ 88,816	$ 1,122,339	34

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 799,117	$ 1,215	$ 18,283	$ 17,068	10	$ 546,418	71
72	Current Year Purchases	15,089	15,090	753	(14,337)	10	753	72
73	Fully Depreciated Assets	162,514					162,514	73
74	Allocated from Management Co.	12,142		246	246	10	9,638	74
75	TOTALS	$ 988,862	$ 16,305	$ 19,282	$ 2,977		$ 719,323	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	Allocated from Management	2010 Infiniti	2010	$ 6,832	$	$ 1,366	$ 1,366	5	$ 2,050	76
77										77
78										78
79										79
80	TOTALS			$ 6,832	$	$ 1,366	$ 1,366		$ 2,050	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)	$ 5,100,987	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,846	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,005	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 93,159	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,843,712	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, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description: 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.		$	$ 1,105	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,105	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.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	1,414	$ 201,823	$	1,414	$ 201,823	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,855	89,020		1,855	89,020	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,731	174,793		2,731	174,793	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				118,966		118,966	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Veterans supplies	L 39, C2					4,084		4,084	13
14	TOTAL			$	6,000	$ 465,636	$ 123,050	6,000	$ 588,686	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.

STATE OF ILLINOIS

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	26,373	26,373	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance - 0 -)	1,368,450	1,368,450	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,674	27,541	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	732,129	1,076,996	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,152,626	$ 2,500,360	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	3,022,713	14
15	Leasehold Improvements, at Historical Cost	661,109	837,580	15
16	Equipment, at Historical Cost	493,847	995,694	16
17	Accumulated Depreciation (book methods)	(710,818)	(1,843,712)	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		40,947	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 514,956	$ 3,298,222	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,667,582	$ 5,798,582	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 161,204	$ 15,810	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,445	32,445	28
29	Short-Term Notes Payable	750,000	750,000	29
30	Accrued Salaries Payable	91,228	91,228	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,070	11,070	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,772	32
33	Accrued Interest Payable		12,991	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	690,962	77,559	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,736,909	$ 1,119,875	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,916,809	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)**	$	$ 3,916,809	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,736,909	$ 5,036,684	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 930,673	$ 761,898	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,667,582	$ 5,798,582	48

*(See instructions.)

Cahokia Nursing & Rehabilitation Center, Inc.
Provider #: 0039636
12/31/11
Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve		267,065
RE Escrow Real Estate Tax		77,802
Short Term Loan Exchange	730,300	730,300
Employee payroll advance	1,829	1,829
Total Line 9-Other Current Assets (Specify)	732,129	1,076,996

Other Long-Term Assets (Specify)		
RE Capitalized Costs		42,048
RE Accumulated Amortization		(1,101)
Total Line 22-Other Long-Term Assets (specify)	-	40,947

Other Current Liabilities (Specify)		
Insurance Premiums Payable	841	841
Accrued Expenses	132,573	132,573
Due to Public Aid	(20,027)	(20,027)
Due/From Cahokia Property LLC	563,402	(50,001)
Due/From Vacant Cahokia Property	14,173	14,173
Total Line 36-Other Current Liabilities (Specify)	690,962	77,559

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,023,759	1
2	Restatements (describe):		2
3	**Prior period Adjustment**	1,177	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,024,936	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	205,737	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	(300,000)	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)**	$ (94,263)	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)**	$ 930,673	24 *

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 5,639,757	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,639,757	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	428,231	6
7	Oxygen	7,182	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 435,413	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***	7,406	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,406	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustment	17,078	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,078	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,099,654	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,167,449	31
32	Health Care	2,456,379	32
33	General Administration	1,486,367	33
	B. Capital Expense		
34	Ownership	542,846	34
	C. Ancillary Expense		
35	Special Cost Centers	158,751	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,893,917	40
41	**Income before Income Taxes (line 30 minus line 40)****	205,737	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 205,737	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.**

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

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,888	2,080	$ 68,323	$ 32.85	1
2	Assistant Director of Nursing	1,920	2,080	56,689	27.25	2
3	Registered Nurses	749	863	24,159	28.01	3
4	Licensed Practical Nurses	26,372	28,130	590,180	20.98	4
5	CNAs & Orderlies	81,729	88,151	920,315	10.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,861	7,776	103,467	13.31	8
9	Activity Director					9
10	Activity Assistants	5,813	6,278	72,006	11.47	10
11	Social Service Workers	3,565	3,888	51,330	13.20	11
12	Dietician					12
13	Food Service Supervisor	1,731	1,941	30,896	15.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,432	21,026	206,971	9.84	15
16	Dishwashers					16
17	Maintenance Workers	3,780	4,139	57,963	14.01	17
18	Housekeepers	16,557	17,862	153,149	8.57	18
19	Laundry	10,321	10,864	96,521	8.88	19
20	Administrator	4,080	4,160	218,753	52.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,659	4,870	121,073	24.86	23
24	Clerical	13,078	14,122	307,164	21.75	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)	202,533	218,228	$ 3,078,959 *	$ 14.11	34

* 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	$ 6,204	L1, C3	35
36	Medical Director	Monthly	3,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,793	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	8,591	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	158	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,996		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, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Teresa Ruberg	Administrator	0	$ 57,462
Robin Suydam	Administrator	0	142,829
Janice Kalz	Administrator	0	18,462
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 218,753

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
Unemployment Consultants	U-E Consultants	$ 1,500
Personnel Planners	U-E Consultants	1,896
McGladrey & Pullen, LLP	Accounting	13,392
American Express	Accounting	2,384
Unacc Accounting	Accounting	(15,250)
ACC accounting	Accounting	16,050
RECL	Accounting	18,000
Field & Goldberg, LLC	Legal	10,835
Helper, Broom, Macdonald, Hebran	Legal	7,897
Stelar Realty	Legal	18,000
Hamlin & Burton	Legal	10,000
See Sch 21A	Legal	(4,381)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 80,323

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,766
Unemployment Compensation Insurance	41,794
FICA Taxes	232,081
Employee Health Insurance	48,378
Employee Meals	6,033
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	2,497
Holiday Expense	2,625
Uniform	(5)
Employee Life Insurance	(529)
TOTAL (agree to Schedule V, line 22, col.8)	$ 395,640

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	3,465
(Indicate # of checks performed)	
Patient Background Checks	
Miscellaneous Inspections & Licenses	1,440
Miscellaneous Dues & Permits	1,463
Allocated from RE Entity	524
Allocated from Management Co.	121
Less: Non-Allowable Lobbying Expense	(3,685)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,328

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,956
Allocated from Management Co.	23
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,979

* Attach copy of IMRF notifications

**See instructions.

Cahokia Nursing & Rehabilitation Center, Inc.
Provider # : 0039636
12/31/11

XIX. SUPPORT SCHEDULE
C. Professional Services

Stephen N. Sher	Legal	18,216
Stone Mcguire & Siegel	Legal	3,629
Aspen Speciality insurance	Legal	10,000
Michigan Peer review	Peer Review	660
Polsinelli Shughart	Legal	1,586
Unacc Legal fees	Legal	(472)
Reclass of misclassified expenses.	Legal	(38,000)
	Total	(4,381)
Total (Agree to Schedule V, Line 19, Column 3)		80,323
Nonallowable Legal Fees		(6,231)
Allocated from Real Estate Entity - Legal		6,900
Allocated from Real Estate Entity - Accounting		429
Allocated from Mangement Company - Legal		172
Allocated from Mangement Company - Accounting		1,193
Total (Agree to Schedule V, Line 19, Column 8)		82,786

Schedule 21A

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center, Inc. # 0039636 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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-$**

(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. $ **5,097** 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. $ **82,125**
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. $ **6,033** 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.