FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0039636

Facility Name: Cahokia Nursing & Rehabilitation Center

Address: 2 Annable 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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/12 to 12/31/12 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) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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 # 0039636 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,454	106	3,551	8,111	8
9	SNF/PED					9
10	ICF	27,058	5,797	578	33,433	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,512	5,903	4,129	41,544	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.67%

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 1,876

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

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

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

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	247,665	27,712	5,220	280,597		280,597		280,597			1
2	Food Purchase		272,298		272,298		272,298	(11,381)	260,917			2
3	Housekeeping	175,659	104,160		279,819		279,819	63	279,882			3
4	Laundry	92,580	10,954		103,534		103,534		103,534			4
5	Heat and Other Utilities			124,327	124,327		124,327	1,473	125,800			5
6	Maintenance	59,442	43,868	16,210	119,520		119,520	496	120,016			6
7	Other (specify):*											7
8	**TOTAL General Services**	575,346	458,992	145,757	1,180,095		1,180,095	(9,349)	1,170,746			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,875,302	62,527	8,687	1,946,516		1,946,516	4,329	1,950,845			10
10a	Therapy											10a
11	Activities	75,636	12,567	150	88,353		88,353		88,353			11
12	Social Services	48,567			48,567		48,567		48,567			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,999,505	75,094	11,837	2,086,436		2,086,436	4,329	2,090,765			16
	C. General Administration											
17	Administrative	225,979		180,000	405,979		405,979	(138,341)	267,638			17
18	Directors Fees											18
19	Professional Services			27,631	27,631		27,631	7,375	35,006			19
20	Dues, Fees, Subscriptions & Promotions			38,632	38,632		38,632	135	38,767			20
21	Clerical & General Office Expenses	419,943		56,384	476,327		476,327	51,489	527,816			21
22	Employee Benefits & Payroll Taxes			408,956	408,956		408,956	5,485	414,441			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,721	6,721		6,721	(3,576)	3,145			24
25	Other Admin. Staff Transportation			4,261	4,261		4,261	2,455	6,716			25
26	Insurance-Prop.Liab.Malpractice			167,494	167,494		167,494	16,970	184,464			26
27	Other (specify):* Mgmt Alloc of Benefi							17,885	17,885			27
28	**TOTAL General Administration**	645,922		890,079	1,536,001		1,536,001	(40,123)	1,495,878			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,220,773	534,086	1,047,673	4,802,532		4,802,532	(45,143)	4,757,389			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 #0039636 Report Period Beginning: 01/01/12 Ending: 12/31/12

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			35,960	35,960		35,960	97,069	133,029			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,936	13,936		13,936	151,161	165,097			32
33	Real Estate Taxes							107,860	107,860			33
34	Rent-Facility & Grounds			432,000	432,000		432,000	(432,000)				34
35	Rent-Equipment & Vehicles							1,061	1,061			35
36	Other (specify):* Mortgage Insurance							19,424	19,424			36
37	TOTAL Ownership			481,896	481,896		481,896	(55,425)	426,471			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,459	605,099	680,558		680,558		680,558			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			322,560	322,560		322,560		322,560			42
43	Other (specify):* Non-Allowable Cos			32,676	32,676		32,676	(32,676)				43
44	TOTAL Special Cost Centers		75,459	960,335	1,035,794		1,035,794	(32,676)	1,003,118			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,220,773	609,545	2,489,904	6,320,222		6,320,222	(133,244)	6,186,978			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 # 0039636 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	(19,700)	30		9
10	Interest and Other Investment Income	(4,522)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(393)	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	(615)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(969)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,628)	43		24
25	Fund Raising, Advertising and Promotional	(1,408)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(19,409)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,644)		$	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)	(71,600)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (71,600)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (133,244)		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

ID# 0039636

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (9,397)	43	1
2	X Ray Expense Med A	(5,877)	43	2
3	Non-Allowable Seminar	(3,677)	24	3
4	Chamber of Commerce	(100)	20	4
5	Managed Care Cost	(358)	43	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
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23				23
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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**	(19,409)		49

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

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%	$ 7,150	$ 7,150	1
2	V	21	Clerical & General Office Expenses		Cahokia Building LLC	100.00%	226	226	2
3	V	26	Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	16,520	16,520	3
4	V	30	Depreciation		Cahokia Building LLC	100.00%	113,319	113,319	4
5	V	32	Interest Income	228	Cahokia Building LLC	100.00%		(228)	5
6	V	32	Interest		Cahokia Building LLC	100.00%	154,710	154,710	6
7	V	32	Amortization		Cahokia Building LLC	100.00%	1,201	1,201	7
8	V	33	Real Estate Tax		Cahokia Building LLC	100.00%	105,069	105,069	8
9	V	34	Rent	432,000	Cahokia Building LLC	100.00%		(432,000)	9
10	V	36	Mortgage Insurance		Cahokia Building LLC	100.00%	19,424	19,424	10
11	V								11
12	V								12
13	V								13
14	Total			$ 432,228			$ 417,619	$ * (14,609)	14

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

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

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 Financial Services Company	100.00%	$ 305	$ 305	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	63	63	16
17	V	5	Utilities		SW Financial Services Company	100.00%	1,473	1,473	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	496	496	18
19	V	17	Administrative	180,000	SW Financial Services Company	100.00%	41,659	(138,341)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,194	1,194	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	235	235	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	51,263	51,263	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	101	101	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	2,455	2,455	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	450	450	25
26	V	27	Other		SW Financial Services Company	100.00%	17,885	17,885	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	3,450	3,450	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	2,791	2,791	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	1,061	1,061	29
30	V				SW Financial Services Company	100.00%			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			$ 180,000			$ 124,881	$ * (55,119)	39

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

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

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	$ 19,234	S & E Medical Supply Co.	100.00%	$ 13,033	$ (6,201)	15
16	V	10	Medical Supplies	742	S & E Medical Supply Co.	100.00%	5,071	4,329	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			$ 19,976			$ 18,104	$ * (1,872)	39

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

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

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	Shabbona	Supportive Living	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Sheldon Wolfe	23.67	Shabbona Healthcare Center	Shabbona	SW Financial	Skokie	Bookkeeping/	3
4	Ronnie Klein as Trustee	4.99			Services Co.		Management Comp.	4
5	Maurice Aaron	4.67	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Michael Klein Revocable Trust	1.99	Oregon Living & Rehabilitation, LLC	Oregon	* SFO Associates	Skokie	Finance Company	6
7	Wanda Bowling	0.67						7
8	Miriam Y Klein as Trustee	6.67			* This entity only relates to Shabbona Healthcare Center,			8
9	Michael A Klein as Trustee	6.67			Franklin Grove Living & Rehab, and Oregon Living & Rehab			9
10	Kenneth Klein	4.99	Beauvais Manor Healthcare and Rehab	St. Louis, MO				10
11	Susan Stern	4.67	Hillside Manor Healthcare and Rehab	St. Louis, MO	Groves Community	Independence, MO	Hospice	11
12	Jonathan B Stern 2001 Trust	1.56	Rancho Manor Healthcare and Rehab	Florissant, MO	Hospice			12
13	Todd A. Stern 2001 Trust	1.56	Rosewood Health & Rehab	Independence, MO	Forest View Senior	Independence, MO	Independent	13
14	Evan M. Stern	1.56	Seasons Care Center	Kansas City, MO	Residences		Living	14
15	Moshe Herman	0.67			White Oak Living	Independence, MO	Residential	15
16	Ora Aaron	4.67			Center		Care	16
17								17
18					Seasons Day Services	Kansas City, MO	Adult Day Care	18
19					Program LLC			19
20								20
21					Cahokia Building LLC	Cahokia	Real Estae	21
22					Caseyville Property LL	Caseyville	Real Estate	22
23					Shabbona Building	Shabbona	Real Estate	23
24					Associates LLC			24
25								25
26					Franklin Grove	Franklin Grove	Real Estate	26
27					Associates			27
28					Oregon Associates	Oregon	Real Estate	28
29								29
30								30

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

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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	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

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

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	6	13.33	Salary	$ 27,880	L17, C7	1
2											2
3											3
4											4
5											5
6			Note: Mr. Wolfe works in excess of 40 hours per week.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,880		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: 01/01/12 Ending: 12/31/12

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 Financial Services 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	609,314	12	$ 3,388	$	54,900	$ 305	1
2	3	Housekeeping	Bed Days Available	609,314	12	696		54,900	63	2
3	5	Utilities	Bed Days Available	609,314	12	16,350		54,900	1,473	3
4	6	Maintenance	Bed Days Available	609,314	12	5,506		54,900	496	4
5	19	Professional Services-Legal	Bed Days Available	609,314	12	1,572		54,900	142	5
6	19	Professional Services-Other	Bed Days Available	609,314	12	11,672		54,900	1,052	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	609,314	12	2,612		54,900	235	7
8	21	Clerical & General Office Expens	Bed Days Available	609,314	12	495,892	495,892	54,900	44,681	8
9	21	Clerical & General Office Expens	Bed Days Available	609,314	12	73,053		54,900	6,582	9
10	24	Travel & Seminar	Bed Days Available	609,314	12	1,122		54,900	101	10
11	25	Other Admin. Staff Transportion	Bed Days Available	609,314	12	27,251		54,900	2,455	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	609,314	12	4,999		54,900	450	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	609,314	12	198,498		54,900	17,885	13
14	33	Real Estate Taxes	Bed Days Available	609,314	12	30,980		54,900	2,791	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	609,314	12	11,776		54,900	1,061	15
16										16
17	17	Administrative - Salary	Avg Hours Worked	45	11	209,100	209,100	6	27,880	17
18	17	Administrative - Salary	Avg Hours Worked	45	11	103,345	103,345	6	13,779	18
19										19
20										20
21	30	Depreciation	Direct Cost	38,287					3,450	21
22										22
23										23
24										24
25	TOTALS					$ 1,197,812	$ 808,337		$ 124,881	25

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

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			$	$		$ 13,033	1
2	10	Medical Supplies	Direct Cost						5,071	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					$	$		$ 18,104	25

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

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	$ 3,861,812	12/1/36	0.0635	$ 154,710	1
2												2
3								Amortization of Mortgage Costs			1,201	3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit	Demand	1/17/11	700,000		1/15/13	0.0425	13,936	6
7												7
8												8
9	TOTAL Facility Related				$23,524.00		$ 4,661,000	$ 3,861,812			$ 169,847	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(4,750)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,750)	14
15	TOTALS (line 9+line14)						$ 4,661,000	$ 3,861,812			$ 165,097	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 19,424 **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 # 0039636 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 128,772	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.)	2011	$ 115,192	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,580)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 118,648	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
	Allocated from Management Co.	2,791	
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.		$ 107,860	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007	201,159	8
2008	146,260	9
2009	127,070	10
2010	122,091	11
2011	115,192	12

2012 Tax Accrual = 115,192 * 1.03 = $118,648

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 112,491.80	$ 112,491.80
2.	06-02.0-310-054	Long Term Care Property	$ 2,700.24	$ 2,700.24
3.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 33,685.36	$ 2,791.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 148,877.40	$ 117,983.04

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

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

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	$ 853,630	4
5			2006		55,818	2,030	40	1,431	(599)	9,303	5
6											6
7	Allocated from Management Co.		1995		35,867		39	1,025	1,025	18,093	7
8											8
	Improvement Type**										
9	Various			1994	17,859	268	20	523	255	16,979	9
10	Various			1995	33,623	337	20	1,681	1,344	29,817	10
11	Various			1996	2,178	56	20	109	53	1,816	11
12	Various			1997	9,423		20	471	471	7,305	12
13	Various			1998	4,800	123	20	240	117	3,480	13
14	Various			1999	16,266	93	20	813	720	11,164	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	758	18
19	Fan Motor			2001	1,123		20	56	56	622	19
20	Drywall-Dining Room			2002	10,650	184	10	177	(7)	10,650	20
21	Door			2002	9,860	184	20	493	309	4,971	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	47,774	26
27	Nursing Station			2003	35,060		20	1,753	1,753	16,361	27
28	Nursing Station			2003	28,692		20	1,435	1,435	14,586	28
29	Nursing Station			2003	6,368		20	318	318	2,892	29
30	Replace Accelerator			2003	968		20	48	48	483	30
31	Sprinkler System			2004	3,610	131	20	181	50	1,535	31
32	Smoke shelter			2004	6,041	220	20	302	82	2,567	32
33	Security System			2005	11,166	406	20	558	152	4,186	33
34	Condensing Unit - 5 Ton			2005	1,959	71	20	98	27	735	34
35	Cabinets and countertops			2005	110,923	4,011	20	5,546	1,535	41,596	35
36	Air Handler			2005	1,549	56	20	78	22	582	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: 01/01/12 Ending: 12/31/12

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	$ 329	20	$ 279	$ (51)	$ 2,090	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	410	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	1,575	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	1,647	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	548	41
42	Door Alarms	2005	3,587	130	20	179	49	1,344	42
43	Wallpaper	2005	17,835		20	892	892	6,689	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	11,100	44
45	6 Doors	2005	1,926	70	20	96	26	722	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	3,898	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	1,829	47
48	Duct Heater	2006	1,195	43	20	60	17	389	48
49	Kitchen Garbage Disposal	2006	1,467		20	73	73	476	49
50	Copper Pipe & Concrete	2006	3,722	135	20	186	51	1,209	50
51	Fence	2006	6,061	358	20	303	(55)	1,970	51
52	Shower Remodel - Hall 400	2006	21,570	784	20	1,079	295	7,011	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	3,170	53
54	Shower Remodel - Hall 200	2006	21,570	784	20	1,079	295	7,011	54
55	Shower Remodel - Hall 500	2006	21,570	784	20	1,079	295	7,011	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	6,363	56
57	Front Entrance	2006	2,150	78	20	108	30	700	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	1,092	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	561	59
60	Compressor-Walk In Freezer	2006	1,784	65	20	89	24	579	60
61	Air Conditioners (5)	2006	2,146		10	215	215	1,396	61
62	Air Conditioners (6)	2006	2,576		20	129	129	838	62
63	Phone System	2006	1,658		20	83	83	539	63
64	Remove & reinstall 6 dry pendents	2007	3,039	111	20	152	41	836	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	2,063	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	158	43	869	66
67	New Window Glass	2007	3,562	130	20	178	48	979	67
68	Paving, Parking Lot & Driveway	2007	32,275	2,012	20	1,614	(398)	8,876	68
69	Handrails	2007	2,980		20	149	149	820	69
70	TOTAL (lines 4 thru 69)		$ 3,703,862	$ 18,937		$ 104,067	$ 85,130	$ 1,201,460	70

**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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	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		$ 3,703,862	$ 18,937		$ 104,067	$ 85,130	$ 1,201,460	1
2	Fire Damper and Roof Vent	2007	5,114	186	20	256	70	1,407	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790		20	440	440	2,418	3
4	Walk In Freezer Door	2007	2,316	84	20	116	32	637	4
5	Replace 4 Inch Main	2008	3,158	115	20	158	43	711	5
6	Sprinkler heads for alarm	2008	29,310	1,066	20	1,466	400	6,596	6
7	Sign	2008	2,685		20	134	134	604	7
8	Hot Water Heater	2009	5,182		20	259	259	907	8
9	Vinyl Flooring	2009	14,512		20	726	726	2,541	9
10	Hot Water Heater	2009	5,094	185	20	255	70	892	10
11	Valves	2010	3,310	120	20	166	46	414	11
12	100 gallon hot water heater	2011	33,232	1,208	20	1,662	454	2,493	12
13	Security system - Phase 1 & 2	2011	21,394	778	20	1,070	292	1,605	13
14									14
15	Patio	2012	5,848	3,070	20	227	(2,843)	227	15
16	Gazebo	2012	19,098	10,027	20	318	(9,709)	318	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Allocated from SW Financial Services Co. - Leasehold Improvements	1995	4,014		20	201	201	3,817	24
25	Allocated from SW Financial Services Co. - Leasehold Improvements	1996	668		20	33	33	554	25
26	Allocated from SW Financial Services Co. - Leasehold Improvements	1997	775		20	39	39	696	26
27	Allocated from SW Financial Services Co. - Leasehold Improvements	1998	663		20	33	33	489	27
28	Allocated from SW Financial Services Co. - Leasehold Improvements	1999	1,840		20	92	92	1,203	28
29	Allocated from SW Financial Services Co. - Leasehold Improvements	2005	3,806		20	190	190	1,427	29
30	Allocated from SW Financial Services Co. - Leasehold Improvements	2007	2,155		20	108	108	592	30
31	Allocated from SW Financial Services Co. - Leasehold Improvements	2009	4,497		20	225	225	787	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,881,322	$ 35,776		$ 112,239	$ 76,463	$ 1,232,793	34

**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: 01/01/12 Ending: 12/31/12

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	$ 811,455	$ 184	$ 19,286	$ 19,102	10	$ 563,706	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	165,265					165,265	73
74	Allocated from Management Co.	11,325		230	230	10	9,219	74
75	TOTALS	$ 988,045	$ 184	$ 19,516	$ 19,332		$ 738,190	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	$ 6,372	$	$ 1,274	$ 1,274	5	$ 3,186	76
77										77
78										78
79										79
80	TOTALS			$ 6,372	$	$ 1,274	$ 1,274		$ 3,186	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)	$ 5,120,739	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,960	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 133,029	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 97,069	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,974,169	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: 01/01/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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.		$	$ 1,061	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,061	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 # 0039636 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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	L39, C3	hrs	$	3,759	$ 270,654	$	3,759	$ 270,654	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,108	101,171		2,108	101,171	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		3,617	231,489		3,617	231,489	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				45,925		45,925	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	L39, C2					29,534		29,534	13
14	TOTAL			$	9,484	$ 603,314	$ 75,459	9,484	$ 678,773	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 # 0039636 Report Period Beginning: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 570,546	$ 900,854	1
2	Cash-Patient Deposits	40,129	40,129	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,000)	1,632,459	1,632,459	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,021	27,698	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	603,992	996,181	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,870,147	$ 3,597,321	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	3,020,126	14
15	Leasehold Improvements, at Historical Cost	686,054	861,196	15
16	Equipment, at Historical Cost	493,847	994,417	16
17	Accumulated Depreciation (book methods)	(746,778)	(1,974,169)	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 (sp See Schedule 17A		39,746	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 503,941	$ 3,186,316	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,374,088	$ 6,783,637	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 145,605	$ 152,630	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,535	40,535	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,608	114,608	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,358	14,358	31
32	Accrued Real Estate Taxes(Sch.IX-B)		118,648	32
33	Accrued Interest Payable		12,808	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,229,060	778,853	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,544,166	$ 1,232,440	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,861,812	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)**	$	$ 3,861,812	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,544,166	$ 5,094,252	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,829,922	$ 1,689,385	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,374,088	$ 6,783,637	48

*(See instructions.)

Cahokia Nursing & Rehabilitation Center, Inc.
Provider #: 0039636
12/31/2012
Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve	-	307,793
RE Escrow Real Estate Tax	-	84,396
Employee Payroll Advance	3,356	3,356
Short Term Loan Exchange	507,309	507,309
Note Receivable - Stockholders	93,327	93,327
Total Line 9-Other Current Assets (Specify)	603,992	996,181

Other Long-Term Assets (Specify)		
RE Capitalized Costs	-	42,048
RE Accumulated Amortization	-	(2,302)
Total Line 22-Other Long-Term Assets (specify)	-	39,746

Other Current Liabilities (Specify)		
Due from State	95,468	95,468
Reimbursement Due	384,931	384,931
Insurance Premiums Payable	-	-
Accrued Expenses	295,099	295,099
Due to Public Aid	(10,818)	(10,818)

Due/From Cahokia Property LLC	450,207	-
Due/From Vacant Cahokia Property	14,173	14,173
Total Line 36-Other Current Liabilities (Specify)	1,229,060	778,853

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 930,673	1
2	Restatements (describe):		2
3	**Prior period Adjustment**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 930,673	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	899,250	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 899,249	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)**	$ 1,829,922	24 *

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

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

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,534,677	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,534,677	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	653,488	6
7	Oxygen	9,812	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 663,300	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***	4,522	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,522	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustment	16,973	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,973	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,219,472	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,180,095	31
32	Health Care	2,086,436	32
33	General Administration	1,536,001	33
	B. Capital Expense		
34	Ownership	481,896	34
	C. Ancillary Expense		
35	Special Cost Centers	713,234	35
36	Provider Participation Fee	322,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,320,222	40
41	**Income before Income Taxes (line 30 minus line 40)****	899,250	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 899,250	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,214,473	44
45	Private Pay - Net Inpatient Revenue	168,370	45
46	Medicare - Net Inpatient Revenue	775,702	46
47	Other-(specify) HOSPICE	58,908	47
48	Other-(specify) VA	317,224	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,534,677	49

* **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.**

*** **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.**

^ - This entity is a cash basis taxpayer.

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

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	1,661	1,941	$ 63,450	$ 32.69	1
2	Assistant Director of Nursing	1,370	1,542	43,121	27.96	2
3	Registered Nurses	2,329	2,354	66,892	28.42	3
4	Licensed Practical Nurses	25,900	27,579	585,606	21.23	4
5	CNAs & Orderlies	84,115	90,610	1,005,888	11.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,090	7,855	110,345	14.05	8
9	Activity Director					9
10	Activity Assistants	5,976	6,479	75,636	11.67	10
11	Social Service Workers	3,247	3,546	48,567	13.70	11
12	Dietician					12
13	Food Service Supervisor	1,737	1,947	31,968	16.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,265	21,297	215,697	10.13	15
16	Dishwashers					16
17	Maintenance Workers	3,556	3,977	59,442	14.95	17
18	Housekeepers	18,363	19,846	175,659	8.85	18
19	Laundry	9,277	9,966	92,580	9.29	19
20	Administrator	4,040	4,160	225,979	54.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,188	5,563	134,625	24.20	23
24	Clerical	11,875	13,181	285,318	21.65	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)	204,989	221,843	$ 3,220,773 *	$ 14.52	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	$ 5,220	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	8,687	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	1,785	L39, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	150	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,842		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janice Kalz	Administrator	0	$ 83,979
Robin Suydam	General Manager	0	142,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 225,979

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 60,000
Management Fees	120,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 180,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Unemployment Consultants	U-E Consultants	$ 1,500
McGladrey LLP	Accounting	17,549
HK Payroll Services Co.	Accounting	138
Field & Goldberg, LLC	Legal	815
Helper, Broom, Macdonald, Hebran	Legal	3,309
The Lowenbaum Partnership, LLC	Legal	4,208
Legal Accrual	Legal	113
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 27,631

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,161
Unemployment Compensation Insurance	47,186
FICA Taxes	241,111
Employee Health Insurance	41,072
Employee Meals	5,485
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	148
Holiday Expense	95
Tuition Reimbursement	170
Employee Life Insurance	(987)
TOTAL (agree to Schedule V, line 22, col.8)	$ 414,441

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	3,695
(Indicate # of checks performed 308)	
Patient Background Checks	
Miscellaneous Inspections & Licenses	1,697
Miscellaneous Dues & Permits	510
Illinois Council on Long Term Care	28,650
Allocated from Management Co.	235
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,767

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,044
Allocated from Management Co.	101
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,145

**See instructions.

Cahokia Nursing & Rehabilitation Center, Inc.
Provider # : 0039636
12/31/2012 Schedule 21C

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	27,631
Nonallowable Legal Fees	(969)
Allocated from Real Estate Entity - Legal	7,150
Allocated from Mangement Company - Legal	142
Allocated from Mangement Company - Accounting	1,052
Total (Agree to Schedule V, Line 19, Column 8)	35,006

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

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 **#** 0039636 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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-$28,650**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22** 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. $ **322,560**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,485** 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.