

		FOR BHF USE					

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**2013**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2013)**

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

<p><b>I. IDPH License ID Number:</b> <u>0039636</u></p> <p><b>Facility Name:</b> <u>Cahokia Nursing &amp; Rehab Ctr</u></p> <p><b>Address:</b> <u>2 Annable Court</u> <u>Cahokia</u> <u>62206</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>St Clair</u></p> <p><b>Telephone Number:</b> <u>(618) 332-0114</u> <b>Fax #</b> <u>(618) 332-1043</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>06/01/1994</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Amanda Springborn</u> <b>Telephone Number:</b> <u>(314) 925-3838</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/13</u> to <u>12/31/13</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) _____            (Title) _____         </td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) <u>McGladrey LLP</u>  <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>            (Telephone) <u>(847) 517-7070</u> <b>Fax #</b> <u>(847) 517-7067</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <span style="float: right;"><b>Phone # (217) 782-1630</b></span> </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> <b>Fax #</b> <u>(847) 517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> <b>Fax #</b> <u>(847) 517-7067</u>							

Facility Name & ID Number Cahokia Nursing & Rehab Ctr

# 0039636 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,498	1,688	4,422	15,608	8
9	SNF/PED					9
10	ICF	21,302	6,435	68	27,805	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,800	8,123	4,490	43,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.29%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year? YES  NO  If YES, enter number of beds certified 30 and days of care provided 2,166

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

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

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

Facility Name &amp; ID Number

Cahokia Nursing &amp; Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	244,978	25,909	7,517	278,404		278,404		278,404		1
2	Food Purchase		282,190		282,190		282,190	(19,287)	262,903		2
3	Housekeeping	183,330	114,176		297,506		297,506	95	297,601		3
4	Laundry	89,106	13,976		103,082		103,082		103,082		4
5	Heat and Other Utilities			118,881	118,881		118,881	1,259	120,140		5
6	Maintenance	62,965	35,322	17,168	115,455		115,455	565	116,020		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	580,379	471,573	143,566	1,195,518		1,195,518	(17,368)	1,178,150		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,750	2,750		2,750		2,750		9
10	Nursing and Medical Records	1,920,334	93,885	12,567	2,026,786		2,026,786	10,090	2,036,876		10
10a	Therapy	108,693			108,693		108,693		108,693		10a
11	Activities	80,641	12,135	105	92,881		92,881		92,881		11
12	Social Services	35,698			35,698		35,698		35,698		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,145,366	106,020	15,422	2,266,808		2,266,808	10,090	2,276,898		16
	<b>C. General Administration</b>										
17	Administrative	229,990		180,000	409,990		409,990	(72,174)	337,816		17
18	Directors Fees										18
19	Professional Services			57,105	57,105		57,105	2,121	59,226		19
20	Dues, Fees, Subscriptions & Promotions			21,966	21,966		21,966	(7,264)	14,702		20
21	Clerical & General Office Expenses	451,221		57,587	508,808		508,808	52,350	561,158		21
22	Employee Benefits & Payroll Taxes			415,942	415,942		415,942	5,662	421,604		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,845	2,845		2,845	372	3,217		24
25	Other Admin. Staff Transportation			6,764	6,764		6,764	1,787	8,551		25
26	Insurance-Prop.Liab.Malpractice			162,264	162,264		162,264	17,720	179,984		26
27	Other (specify):* <b>Mgmt Alloc Benefits</b>							15,237	15,237		27
28	<b>TOTAL General Administration</b>	681,211		904,473	1,585,684		1,585,684	15,811	1,601,495		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,406,956	577,593	1,063,461	5,048,010		5,048,010	8,533	5,056,543		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 &amp; ID Number

Cahokia Nursing &amp; Rehab Ctr

#0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			28,424	28,424		28,424	104,331	132,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							144,867	144,867			32
33	Real Estate Taxes							92,730	92,730			33
34	Rent-Facility & Grounds			432,000	432,000		432,000	(432,000)				34
35	Rent-Equipment & Vehicles							1,115	1,115			35
36	Other (specify):* Mortgage Insurance							13,558	13,558			36
37	<b>TOTAL Ownership</b>			460,424	460,424		460,424	(75,399)	385,025			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,468	549,360	670,828		670,828		670,828			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			328,299	328,299		328,299		328,299			42
43	Other (specify):* Non-Allowable Co			33,290	33,290		33,290	(33,290)				43
44	<b>TOTAL Special Cost Centers</b>		121,468	910,949	1,032,417		1,032,417	(33,290)	999,127			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,406,956	699,061	2,434,834	6,540,851		6,540,851	(100,156)	6,440,695			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 & Rehab Ctr

# 0039636

Report Period Beginning: 01/01/13

Ending: 12/31/13

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(17,099)	30		9
10	Interest and Other Investment Income	(8,604)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(276)	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	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,969)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax	(13,000)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(25,132)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (73,980)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(26,176)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (26,176)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (100,156)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>					
48		49		50	51
					52

Cahokia Nursing & Rehab Ctr

ID# 0039636

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense Med A	\$ (9,554)	43	1
2	X Ray Expense Med A	(3,689)	43	2
3	Managed Care Cost	(4,402)	43	3
4	Disallow lobbying expense	(7,487)	20	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				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	<b>Total</b>		(25,132)	49

**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.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Services	\$	Cahokia Building LLC	100.00%	\$ 8,425	\$ 8,425	1
2	V	21 Clerical & General Office Expenses		Cahokia Building LLC	100.00%	55	55	2
3	V	26 Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	17,075	17,075	3
4	V	30 Depreciation		Cahokia Building LLC	100.00%	118,043	118,043	4
5	V	32 Interest Income	204	Cahokia Building LLC	100.00%		(204)	5
6	V	32 Interest		Cahokia Building LLC	100.00%	152,474	152,474	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%	89,906	89,906	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%	13,558	13,558	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 432,204			\$ 400,737	\$ * (31,467)	14

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



VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Financial Services Company	100.00%	\$ 266	\$	266	15
16	V	3 Housekeeping		SW Financial Services Company	100.00%	95		95	16
17	V	5 Utilities		SW Financial Services Company	100.00%	1,259		1,259	17
18	V	6 Maintenance		SW Financial Services Company	100.00%	565		565	18
19	V	17 Administrative	120,000	SW Financial Services Company	100.00%	47,826		(72,174)	19
20	V	19 Professional Services		SW Financial Services Company	100.00%	1,196		1,196	20
21	V	20 Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	223		223	21
22	V	21 Clerical & General Office Expenses		SW Financial Services Company	100.00%	52,295		52,295	22
23	V	24 Travel & Seminar		SW Financial Services Company	100.00%	372		372	23
24	V	25 Other Admin. Staff Transportation		SW Financial Services Company	100.00%	1,787		1,787	24
25	V	26 Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	645		645	25
26	V	27 Management Allocated Benefits		SW Financial Services Company	100.00%	15,237		15,237	26
27	V	30 Depreciation		SW Financial Services Company	100.00%	3,387		3,387	27
28	V	33 Real Estate Taxes		SW Financial Services Company	100.00%	2,824		2,824	28
29	V	35 Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	1,115		1,115	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		\$ 120,000			\$ 129,092	\$ *	9,092	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 31,945	S & E Medical Supply Co.	100.00%	\$ 18,054	\$ (13,891)
16	V	10 Medical Supplies	5,385	S & E Medical Supply Co.	100.00%	15,475	10,090
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 37,330			\$ 33,529	\$ * (3,801)

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

Facility Name & ID Number

Cahokia Nursing & Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 Living Center, LLC	Shabbona	Supportive Living Facility	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 Services Co.	Skokie	Bookkeeping/Management Comp	3
4	Ronnie Klein as Trustee	4.99						4
5	Maurice Aaron	4.67	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply Co	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	Green Acres Healthcare Rehab Center	Amboy				7
8	Miriam Y Klein as Trustee	6.67			* This entity only relates to Shabbona Healthcare Center, Franklin Grove Living & Rehab, and Oregon Living & Rehab			8
9	Michael A Klein as Trustee	6.67						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 Hospice	Independence, MO	Hospice	11
12	Jonathan B Stern 2001 Trust	1.56	Rancho Manor Healthcare and Rehab	Florissant, MO				12
13	Todd A. Stern 2001 Trust	1.56	Rosewood Health & Rehab	Independence, MO	Forest View Senior Residences	Independence, MO	Independent Living	13
14	Evan M. Stern	1.56	Seasons Care Center	Kansas City, MO	White Oak Living Center	Independence, MO	Residential Care	14
15	Moshe Herman	0.67						15
16	Ora Aaron	4.67						16
17								17
18					Seasons Day Services Program LLC	Kansas City, MO	Adult Day Care	18
19								19
20								20
21					Cahokia Building LLC	Cahokia	Real Estate	21
22					Caseyville Property LI	Caseyville	Real Estate	22
23					Shabbona Building Associates LLC	Shabbona	Real Estate	23
24								24
25								25
26					Franklin Grove Associates	Franklin Grove	Real Estate	26
27								27
28					Oregon Associates	Oregon	Real Estate	28
29					Green Acres Property,	Amboy	Real Estate	29
30								30

Facility Name & ID Number

Cahokia Nursing & Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/13 Ending: 12/31/13

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	6.25	13.33	Salary	\$ 29,917	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	\$ 29,917		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 & Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	633,958	12	\$ 3,076	\$ 54,750	\$ 266	1	
2	3	Housekeeping	Bed Days Available	633,958	12	1,102	54,750	95	2	
3	5	Utilities	Bed Days Available	633,958	12	14,583	54,750	1,259	3	
4	6	Maintenance	Bed Days Available	633,958	12	6,537	54,750	565	4	
5	19	Professional Services-Legal	Bed Days Available	633,958	12	2,469	54,750	213	5	
6	19	Professional Services-Other	Bed Days Available	633,958	12	11,379	54,750	983	6	
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	633,958	12	2,583	54,750	223	7	
8	21	Clerical & General Office Expens	Bed Days Available	633,958	12	522,868	54,750	45,156	8	
9	21	Clerical & General Office Expens	Bed Days Available	633,958	12	82,658	54,750	7,139	9	
10	24	Travel & Seminar	Bed Days Available	633,958	12	4,312	54,750	372	10	
11	25	Other Admin. Staff Transportation	Bed Days Available	633,958	12	20,693	54,750	1,787	11	
12	26	Insurance-Prop, Liab & Malprac	Bed Days Available	633,958	12	7,467	54,750	645	12	
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	633,958	12	176,429	54,750	15,237	13	
14	33	Real Estate Taxes	Bed Days Available	633,958	12	32,704	54,750	2,824	14	
15	35	Rent - Equipment & Vehicles	Bed Days Available	633,958	12	12,906	54,750	1,115	15	
16									16	
17	17	Administrative - Salary	Avg Hours Worked	45	12	215,400	215,400	6	29,917	17
18	17	Administrative - Salary	Avg Hours Worked	45	12	128,945	128,945	6	17,909	18
19									19	
20									20	
21	30	Depreciation	Direct Cost	39,214					3,387	21
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,246,111	\$ 344,345	\$ 129,092	25	

Facility Name & ID Number Cahokia Nursing & Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 18,054	1
2	10	Medical Supplies	Direct Cost					15,475	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				\$	\$		\$ 33,529	25

**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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Heartland Bank		X	Mortgage	\$23,524.00	11/27/01	\$ 3,961,000	\$ 3,804,586	12/1/36	0.0635	\$ 152,474	1					
2												2					
3							Amortization of Mortgage Costs				1,201	3					
4												4					
5												5					
<b>Working Capital</b>																	
6	MB Financial		X	Line of Credit	Demand	1/17/11	700,000		1/15/13	0.0425		6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$23,524.00		\$ 4,661,000	\$ 3,804,586			\$ 153,675	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11											(8,808)	11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(8,808)	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 4,661,000	\$ 3,804,586			\$ 144,867	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 13,558 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.)



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

**B. Real Estate Taxes**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>			
1. Real Estate Tax accrual used on 2012 report.		\$ <b>118,648</b>	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.)	2012	\$ <b>102,970</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>(15,678)</b>	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>105,584</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
	Allocated from Management Co.	<b>2,824</b>	
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>92,730</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2008	<b>146,260</b>	8
	2009	<b>127,070</b>	9
	2010	<b>122,091</b>	10
	2011	<b>115,192</b>	11
	2012	<b>102,970</b>	12
<b>2013 Tax Accrual = 102,970 * 1.025 = \$105,584</b>			
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cahokia Nursing & Rehab Ctr 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 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-02.0-310-055</u>	<u>Long Term Care Property</u>	\$ <u>100,555.84</u>	\$ <u>100,555.84</u>
2. <u>06-02.0-310-054</u>	<u>Long Term Care Property</u>	\$ <u>2,413.72</u>	\$ <u>2,413.72</u>
3. <u>10-28-412-049-0000</u>	<u>SW Financial Services Co. Allocation</u>	\$ <u>35,417.00</u>	\$ <u>2,824.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>138,386.56</u></u>	\$ <u><u>105,793.56</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr

# 0039636 Report Period Beginning:

01/01/13 Ending:

12/31/13

**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  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>2001</u>	<u>\$ 230,000</u>	<u>1</u>
2	<u>Office Space for Employees</u>		<u>2006</u>	<u>15,000</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 245,000</b>	<b>3</b>

Facility Name &amp; ID Number Cahokia Nursing &amp; Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	2001		\$ 2,928,441	\$	15-40	\$ 68,691	\$ 68,691	\$ 922,321	4
5		2006		55,818	2,030	40	1,431	(599)	10,734	5
6										6
7	Allocated from Management Co.	1995		34,517		39	986	986	18,398	7
8										8
Improvement Type**										
9	Various		1994	17,859	268	20	523	255	17,502	9
10	Various		1995	33,623	337	20	1,681	1,344	31,498	10
11	Various		1996	2,178	56	20	109	53	1,925	11
12	Various		1997	9,423		20	471	471	7,776	12
13	Various		1998	4,800	123	20	240	117	3,720	13
14	Various		1999	16,266	93	20	813	720	11,977	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	824	18
19	Fan Motor		2001	1,123		20	56	56	678	19
20	Drywall-Dining Room		2002	10,650	184	10		(184)	10,650	20
21	Door		2002	9,860	184	20	493	309	5,464	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	52,674	26
27	Nursing Station		2003	35,060		20	1,753	1,753	18,114	27
28	Nursing Station		2003	28,692		20	1,435	1,435	16,021	28
29	Nursing Station		2003	6,368		20	318	318	3,210	29
30	Replace Accelerator		2003	968		20	48	48	531	30
31	Sprinkler System		2004	3,610	131	20	181	50	1,716	31
32	Smoke shelter		2004	6,041	220	20	302	82	2,869	32
33	Security System		2005	11,166	406	20	558	152	4,744	33
34	Condensing Unit - 5 Ton		2005	1,959	71	20	98	27	833	34
35	Cabinets and countertops		2005	110,923	4,011	20	5,546	1,535	47,142	35
36	Air Handler		2005	1,549	56	20	78		660	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 &amp; ID Number Cahokia Nursing &amp; Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Asphalt Parking Lot	2005	\$ 5,570	\$ 329	20	\$ 279	\$ (51)	\$ 2,369	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	465	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	1,785	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	1,867	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	621	41
42	Door Alarms	2005	3,587	130	20	179	49	1,523	42
43	Wallpaper	2005	17,835		20	892	892	7,581	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	12,580	44
45	6 Doors	2005	1,926	70	20	96	26	818	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	4,418	46
47	Vinyl Flooring	2005	4,878	244	20	244		2,073	47
48	Duct Heater	2006	1,195	60	20	60		449	48
49	Kitchen Garbage Disposal	2006	1,467	73	20	73		549	49
50	Copper Pipe & Concrete	2006	3,722	186	20	186		1,395	50
51	Fence	2006	6,061	303	20	303		2,273	51
52	Shower Remodel - Hall 400	2006	21,570	1,079	20	1,079		8,090	52
53	Tile Kitchen Floor	2006	9,750	488	20	488		3,658	53
54	Shower Remodel - Hall 200	2006	21,570	1,079	20	1,079		8,090	54
55	Shower Remodel - Hall 500	2006	21,570	1,079	20	1,079		8,090	55
56	Sprinkler System - new pipe	2006	19,579	979	20	979		7,342	56
57	Front Entrance	2006	2,150	108	20	108		808	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	168	20	168		1,260	58
59	3 Ton Condensing Unit	2006	1,729	86	20	86		647	59
60	Compressor-Walk In Freezer	2006	1,784	89	20	89		668	60
61	Air Conditioners (5)	2006	2,146	215	10	215		1,611	61
62	Air Conditioners (6)	2006	2,576	129	20	129		967	62
63	Phone System	2006	1,658	83	20	83		622	63
64	Remove & reinstall 6 dry pendants	2007	3,039	111	20	152	41	988	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	2,438	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	84	(32)	953	66
67	New Window Glass	2007	3,562	130	20	178	48	1,157	67
68	Paving, Parking Lot & Driveway	2007	32,275	2,012	20	113	(1,900)	8,989	68
69	Handrails	2007	2,980		20	149	149	969	69
70	TOTAL (lines 4 thru 69)		\$ 3,702,512	\$ 20,923		\$ 102,275	\$ 81,331	\$ 1,303,058	70

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

Facility Name &amp; ID Number Cahokia Nursing &amp; Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>	2007	\$ 3,702,512	\$ 20,923		\$ 102,275	\$ 81,353	\$ 1,303,058	1
2	Fire Damper and Roof Vent	2007	5,114	141	20	256	115	1,663	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790	75	20	440	365	2,858	3
4	Walk In Freezer Door	2008	2,316	116	20	116		753	4
5	Replace 4 Inch Main	2008	3,158	116	20	158	42	869	5
6	Sprinkler heads for alarm	2008	29,310	1,466	20	1,466		8,062	6
7	Sign	2009	2,685	134	20	134		738	7
8	Hot Water Heater	2009	5,182	259	20	259	(0)	1,166	8
9	Vinyl Flooring	2009	14,512	726	20	726	0	3,267	9
10	Hot Water Heater	2010	5,094	255	20	255	0	1,147	10
11	Valves	2011	3,310	166	20	166		580	11
12	100 gallon hot water heater	2011	33,232	1,662	20	1,662		4,155	12
13	Security system - Phase 1 & 2	2011	21,394	535	20	1,070	535	2,675	13
14									14
15	Patio	2012	5,848		20	455	455	682	15
16	Gazebo	2012	19,098		20	637	637	955	16
17									17
18	Fire Alarm Replacement	2013	17,758		20	444	444	444	18
19									19
20	Adjustment to Current Booked Depreciation			(31,409)			31,409		20
21									21
22									22
23									23
24	Allocated from SW Financial Services Co. - Leasehold Improvement:	1995	3,863		20	190	190	3,863	24
25	Allocated from SW Financial Services Co. - Leasehold Improvement:	1996	643		20	32	32	565	25
26	Allocated from SW Financial Services Co. - Leasehold Improvement:	1997	746		20	37	37	707	26
27	Allocated from SW Financial Services Co. - Leasehold Improvement:	1998	638		20	32	32	502	27
28	Allocated from SW Financial Services Co. - Leasehold Improvement:	1999	1,770		20	89	89	1,247	28
29	Allocated from SW Financial Services Co. - Leasehold Improvement:	2005	3,662		20	183	183	1,556	29
30	Allocated from SW Financial Services Co. - Leasehold Improvement:	2007	2,073		20	104	104	674	30
31	Allocated from SW Financial Services Co. - Leasehold Improvement:	2009	4,329		20	216	216	974	31
32	Allocated from SW Financial Services Co. - Leasehold Improvement:	2013	2,311		20	58	58	58	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,899,347	\$ (4,838)		\$ 111,457	\$ 116,295	\$ 1,343,215	34

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

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	\$ 32,290	\$ 19,286	\$ (13,004)	10	\$ 582,992	71
72	Current Year Purchases	11,041	973	552	(421)	10	552	72
73	Fully Depreciated Assets	165,265					165,265	73
74	Allocated from Mgmt	11,135		233	233	10	9,105	74
75	TOTALS	\$ 998,896	\$ 33,262	\$ 20,071	\$ (13,191)		\$ 757,914	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 Mgmt	2010 Infinity	2010	\$ 6,132	\$	\$ 1,227	\$ 1,227	5	\$ 4,293	76
77										77
78										78
79										79
80	TOTALS			\$ 6,132	\$	\$ 1,227	\$ 1,227		\$ 4,293	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)	\$ 5,149,375	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,424	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,755	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 104,331	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,105,422	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.



**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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ N/A Description: \_\_\_\_\_

(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	<u>Allocated from Management Co.</u>		\$	\$ <u>1,115</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,115</u>	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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/13 Ending: 12/31/13  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.                  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	\$	3,533	\$ 254,398	\$	3,533	\$ 254,398	1	
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,545	111,259		1,545	111,259	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	L39, C3	hrs		2,551	183,703		2,551	183,703	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 prescripts				62,488		62,488	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Veterans Supplies</u>	L39, C2					58,980		58,980	13	
14	<b>TOTAL</b>			\$	7,629	\$ 549,360	\$ 121,468	7,629	\$ 670,828	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.

Facility Name & ID Number Cahokia Nursing & Rehab Ctr# 0039636Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 481,375	\$ 825,809	1
2	Cash-Patient Deposits	48,269	48,269	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>15,632</u> )	1,980,402	1,980,402	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,780	38,053	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	570,852	873,453	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,103,678	\$ 3,765,986	10
	<b>B. Long-Term Assets</b>			
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	3,018,775	14
15	Leasehold Improvements, at Historical Cost	639,715	880,572	15
16	Equipment, at Historical Cost	286,351	1,005,028	16
17	Accumulated Depreciation (book methods)	(556,664)	(2,105,422)	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 (spec <u>Accum Amortization</u> )		38,545	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 440,220	\$ 3,082,498	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,543,898	\$ 6,848,484	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 50,119	\$ 57,144	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,222	40,222	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,301	131,301	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,672	14,672	31
32	Accrued Real Estate Taxes(Sch.IX-B)		105,584	32
33	Accrued Interest Payable		12,618	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	805,405	713,126	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,041,719	\$ 1,074,667	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		3,804,586	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 3,804,586	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,041,719	\$ 4,879,253	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,502,179	\$ 1,969,231	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,543,898	\$ 6,848,484	48

\*(See instructions.)

Cahokia Nursing & Rehabilitation Center, Inc.  
 Provider #: 0039636  
 12/31/2013  
 Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve	-	202,650
RE Escrow Real Estate Tax	-	99,951
Employee Payroll Advance	1,489	1,489
Short Term Loan Exchange	476,036	476,036
Note Receivable - Stockholders	93,327	93,327
<b>Total Line 9-Other Current Assets (Specify)</b>	<b>570,852</b>	<b>873,453</b>

Other Current Liabilities (Specify)

Due from State	78,936	78,936
Reimbursement Due	300,700	300,700
Insurance Premiums Payable	6,702	6,702
Accrued Expenses	318,138	318,138
Due to Public Aid	(5,523)	(5,523)
Due/From Cahokia Property LLC	92,279	-
Due/From Vacant Cahokia Property	14,173	14,173
<b>Total Line 36-Other Current Liabilities (Specify)</b>	<b>805,405</b>	<b>713,126</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,829,922	1
2	Restatements (describe):		2
3	Prior period		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,829,922	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	672,253	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	4	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 672,257	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,502,179	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,651,764	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,651,764	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	541,856	6
7	Oxygen	10,880	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 552,736	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,604	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,604	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,213,104	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,195,518	31
32	Health Care	2,266,808	32
33	General Administration	1,585,684	33
<b>B. Capital Expense</b>			
34	Ownership	460,424	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	704,118	35
36	Provider Participation Fee	328,299	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,540,851	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	672,253	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 672,253	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 5,093,270	44
45	Private Pay - Net Inpatient Revenue	150,511	45
46	Medicare - Net Inpatient Revenue	935,531	46
47	Other-(specify) <u>Hospice</u>	35,814	47
48	Other-(specify) <u>VA</u>	436,638	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,651,764	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 & Rehab Ctr

# 0039636

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,048	2,080	\$ 64,260	\$ 30.89	1
2	Assistant Director of Nursing	2,020	2,082	55,929	26.86	2
3	Registered Nurses	4,446	4,642	122,476	26.38	3
4	Licensed Practical Nurses	24,993	26,701	563,313	21.10	4
5	CNAs & Orderlies	89,798	96,720	1,114,356	11.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,468	7,364	108,693	14.76	8
9	Activity Director					9
10	Activity Assistants	6,298	6,818	80,641	11.83	10
11	Social Service Workers	1,937	2,097	35,698	17.02	11
12	Dietician					12
13	Food Service Supervisor	1,448	1,785	30,078	16.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,168	21,009	214,900	10.23	15
16	Dishwashers					16
17	Maintenance Workers	3,791	4,213	62,965	14.95	17
18	Housekeepers	19,042	20,590	183,330	8.90	18
19	Laundry	8,970	9,671	89,106	9.21	19
20	Administrator	4,048	4,160	229,990	55.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	12,725	13,661	315,132	23.07	23
24	Clerical	6,121	6,588	136,089	20.66	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)	213,321	230,181	\$ 3,406,956 *	\$ 14.80	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 7,517	L1, C3	35
36	Medical Director	Monthly	2,750	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,567	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	418	L39, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	105	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,357		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Janice Kalz	Administrator	0	\$ 87,990	Workers' Compensation Insurance	\$ 59,144	IDPH License Fee	\$	
Robin Suydam	General Manager	0	142,000	Unemployment Compensation Insurance	40,514	Advertising: Employee Recruitment		
				FICA Taxes	256,184	Health Care Worker Background Check		
				Employee Health Insurance	58,609	(Indicate # of checks performed <u>290</u> )	3,475	
				Employee Meals	5,662	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Inspections & Licenses	628	
				Miscellaneous Employee Benefits	954	Miscellaneous Dues & Permits	605	
				Holiday Expense	1,186	Illinois Council on Long Term Care	17,258	
				Tuition Reimbursement				
				Employee Life Insurance	(649)	Allocated from Management Co.	223	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(7,487)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 229,990	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 421,604		\$ 14,702		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
SW Financial Services Co.-Home Office	\$ 60,000			N/A		\$	Out-of-State Travel	\$
Management Fees	120,000							
(Eliminated on Schedule V, Column 7)								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 180,000				In-State Travel	
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type	Amount		\$ <th colspan="2">Allocated from Management Co.</th>			Allocated from Management Co.	
Unemployment Consultants	U-E Consultants	\$ 3,275					372	
McGladrey LLP	Accounting	18,823						
HK Payroll Services Co.	Accounting	65						
Unacc Accounting	Accounting	400						
Field & Goldberg, LLC	Legal	919						
Helper, Broom, Macdonald, Hebrani	Legal	21,461						
Sandberg Phoenix & Von Gontard P	Legal	5,572						
Dan Farrah and Christian Willenboi	Legal	950						
Legal Accrual	Legal	5,640						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 57,105	\$			Entertainment Expense	
							( )	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 3,217	

\* Attach copy of IMRF notifications

\*\*See instructions.

Cahokia Nursing & Rehabilitation Center, Inc.

Provider # : 0039636

12/31/2013

Schedule 21C

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3) 57,105

Nonallowable Legal Fees (7,500)

Allocated from Real Estate Entity - Legal 8,425

Allocated from Mangement Company - Legal 213

Allocated from Mangement Company - Accounting 983

Total ( Agree to Schedule V, Line 19, Column 8) 59,226

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3										N/A		
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Cahokia Nursing &amp; Rehab Ctr

# 0039636

Report Period Beginning: 01/01/13

Ending: 12/31/13

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. Illinois Council on Long Term Care-\$17,258
- (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. \$ 175 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. \$ 328,299  
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. \$ 5,662 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/S
- 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.