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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0039636

Facility Name: Cahokia Nursing & Rehab Ctr

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 01/01/14 to 12/31/14 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) Sheldon Wolfe
(Title) Officer

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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,725	12	5,238	11,975	8
9	SNF/PED					9
10	ICF	24,528	431	3,568	28,527	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,253	443	8,806	40,502	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.98%

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 1,929

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	245,268	24,476	6,501	276,245		276,245		276,245			1
2	Food Purchase		276,540		276,540		276,540	(14,911)	261,629			2
3	Housekeeping	201,712	95,765		297,477		297,477	36	297,513			3
4	Laundry	80,944	19,338		100,282		100,282		100,282			4
5	Heat and Other Utilities			121,641	121,641		121,641	1,312	122,953			5
6	Maintenance	63,061	89,059	19,028	171,148		171,148	294	171,442			6
7	Other (specify):*											7
8	**TOTAL General Services**	590,985	505,178	147,170	1,243,333		1,243,333	(13,269)	1,230,064			8
	B. Health Care and Programs											
9	Medical Director			3,250	3,250		3,250		3,250			9
10	Nursing and Medical Records	1,879,943	91,008	11,543	1,982,494		1,982,494	7,154	1,989,648			10
10a	Therapy	94,384			94,384		94,384		94,384			10a
11	Activities	83,862	10,714	105	94,681		94,681		94,681			11
12	Social Services	41,628			41,628		41,628		41,628			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,099,817	101,722	14,898	2,216,437		2,216,437	7,154	2,223,591			16
	C. General Administration											
17	Administrative	242,802		120,000	362,802		362,802	(82,160)	280,642			17
18	Directors Fees											18
19	Professional Services			36,760	36,760		36,760	1,902	38,662			19
20	Dues, Fees, Subscriptions & Promotions			25,097	25,097		25,097	(3,671)	21,426			20
21	Clerical & General Office Expenses	536,189		48,166	584,355		584,355	53,130	637,485			21
22	Employee Benefits & Payroll Taxes			421,736	421,736		421,736	5,855	427,591			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,522	3,522		3,522	139	3,661			24
25	Other Admin. Staff Transportation			6,468	6,468		6,468	1,802	8,270			25
26	Insurance-Prop.Liab.Malpractice			154,570	154,570		154,570	23,144	177,714			26
27	Other (specify):* **Mgmt Alloc Benefits**							17,206	17,206			27
28	**TOTAL General Administration**	778,991		816,319	1,595,310		1,595,310	17,347	1,612,657			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,469,793	606,900	978,387	5,055,080		5,055,080	11,232	5,066,312			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 & Rehab Ctr #0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			44,176	44,176		44,176	98,495	142,671			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93	93		93	148,005	148,098			32
33	Real Estate Taxes							111,651	111,651			33
34	Rent-Facility & Grounds			432,000	432,000		432,000	(432,000)				34
35	Rent-Equipment & Vehicles							992	992			35
36	Other (specify):* **Mortgage Insurance**							18,923	18,923			36
37	**TOTAL Ownership**			476,269	476,269		476,269	(53,934)	422,335			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,856	539,973	577,829		577,829		577,829			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			320,282	320,282		320,282		320,282			42
43	Other (specify):* **Non-Allowable Cos**			24,100	24,100		24,100	(24,100)				43
44	**TOTAL Special Cost Centers**		37,856	884,355	922,211		922,211	(24,100)	898,111			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,469,793	644,756	2,339,011	6,453,560		6,453,560	(66,802)	6,386,758			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: 01/01/14 Ending: 12/31/14

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	(31,138)	30		9
10	Interest and Other Investment Income	(3,142)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(282)	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	(5,259)	43		18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,465)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,675)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,500)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(18,550)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,411)		$	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)	(391)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (391)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (66,802)		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 & Rehab Ctr

ID# 0039636

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (4,027)	43	1
2	X Ray Expense Med A	(4,359)	43	2
3	Managed Care Cost	(3,598)	43	3
4	Disallow lobbying expense	(4,381)	20	4
5	Offset miscellaneous income	(2,185)	21	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	**Total**	(18,550)		49

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 8,425	$ 8,425	1
2	V	20	Licenses		Cahokia Building LLC	100.00%	500	500	2
3	V	26	Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	22,140	22,140	3
4	V	30	Depreciation		Cahokia Building LLC	100.00%	126,412	126,412	4
5	V	32	Interest Income	201	Cahokia Building LLC	100.00%		(201)	5
6	V	32	Interest		Cahokia Building LLC	100.00%	150,147	150,147	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%	101,690	101,690	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%	18,923	18,923	10
11	V								11
12	V								12
13	V								13
14	Total			$ 432,201			$ 429,438	$ * (2,763)	14

*** 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: 01/01/14 Ending: 12/31/14

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%	$ 224	$ 224	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	36	36	16
17	V	5	Utilities		SW Financial Services Company	100.00%	1,312	1,312	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	294	294	18
19	V	17	Administrative	120,000	SW Financial Services Company	100.00%	37,840	(82,160)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,462	1,462	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	210	210	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	55,315	55,315	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	139	139	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	1,802	1,802	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	1,004	1,004	25
26	V	27	Management Allocated Benefits		SW Financial Services Company	100.00%	17,206	17,206	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	3,221	3,221	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	3,441	3,441	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	992	992	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			$ 124,498	$ * 4,498	39

* 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: 01/01/14 Ending: 12/31/14

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	$ 21,553	S & E Medical Supply Co.	100.00%	$ 12,273	$ (9,280)	15
16	V	10	Medical Supplies	1,005	S & E Medical Supply Co.	100.00%	8,159	7,154	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			$ 22,558			$ 20,432	$ * (2,126)	39

* 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: 01/01/14 Ending: 12/31/14

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	Prairie Crossing Supp	Shabbona	Supportive Living	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Sheldon Wolfe	23.67	Green Acres Healthcare Rehab Center	Amboy	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				6
7	Wanda Bowling	0.67	Prairie Crossing Living & Rehab Center	Shabbona	Groves Community	Independence, MO	Hospice	7
8	Miriam Y Klein as Trustee	6.67			Hospice			8
9	Michael A Klein as Trustee	6.67	Tower Hill Rehabilitation LLC	South Elgin	Forest View Senior	Independence, MO	Independent	9
10	Kenneth Klein	4.99			Residences		Living	10
11	Susat Stern	4.67	Beauvais Manor Healthcare and Rehab	St. Louis, MO	White Oak Living	Independence, MO	Residential	11
12	Jonathan B Stern 2001 Trust	1.56	Hillside Manor Healthcare and Rehab	St. Louis, MO	Center		Care	12
13	Todd A. Stern 2001 Trust	1.56	Rancho Manor Healthcare and Rehab	Florissant, MO				13
14	Evan M. Stern	1.56	Rosewood Health & Rehab	Independence, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15	Moshe Herman	0.67	Seasons Care Center	Kansas City, MO	Program LLC			15
16	Ora Aaron	4.67	Carriage Square Living & Rehab	St. Joseph, MO				16
17					Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20								20
21					Franklin Grove	Franklin Grove	Real Estate	21
22					Associates			22
23					Oregon Associates	Oregon	Real Estate	23
24					Shabbona Building	Shabbona	Real Estate	24
25					Associates LLC			25
26								26
27					Tower Hill Property L	South Elgin	Real Estate	27
28								28
29								29
30								30

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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					Carriage Square Prop	St. Joseph, MO	Real Estate	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: 01/01/14 Ending: 12/31/14

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	5.5	0.12	Salary	$ 19,983	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	$ 19,983		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: 01/01/14 Ending: 12/31/14

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	663,601	13	$ 2,712	$	54,750	$ 224	1
2	3	Housekeeping	Bed Days Available	663,601	13	434		54,750	36	2
3	5	Utilities	Bed Days Available	663,601	13	15,908		54,750	1,312	3
4	6	Maintenance	Bed Days Available	663,601	13	3,567		54,750	294	4
5	19	Professional Services-Legal	Bed Days Available	663,601	13	1,827		54,750	151	5
6	19	Professional Services-Other	Bed Days Available	663,601	13	15,885		54,750	1,311	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	663,601	13	2,546		54,750	210	7
8	21	Clerical & General Office Expens	Bed Days Available	663,601	13	549,341	549,341	54,750	45,323	8
9	21	Clerical & General Office Expens	Bed Days Available	663,601	13	121,114		54,750	9,992	9
10	24	Travel & Seminar	Bed Days Available	663,601	13	1,687		54,750	139	10
11	25	Other Admin. Staff Transportion	Bed Days Available	663,601	13	21,838		54,750	1,802	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	663,601	13	12,166		54,750	1,004	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	663,601	13	208,541		54,750	17,206	13
14	33	Real Estate Taxes	Bed Days Available	663,601	13	41,712		54,750	3,441	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	663,601	13	12,022		54,750	992	15
16										16
17	17	Administrative - Salary	Avg Hours Worked	45	13	163,500	163,500	6	19,983	17
18	17	Administrative - Salary	Avg Hours Worked	45	13	146,104	146,104	6	17,857	18
19										19
20										20
21	30	Depreciation	Direct Cost	39,045	13				3,221	21
22										22
23										23
24										24
25	TOTALS					$ 1,320,904	$ 858,945		$ 124,498	25

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 12,273	1
2	10	Medical Supplies	Direct Cost						8,159	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					$	$		$ 20,432	25

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 3,745,040	12/1/36	0.0635	$ 150,147	1
2	Amortization of Mortgage Cost		X								1,201	2
3												3
4												4
5												5
	Working Capital											
6	Late Payment Fee										93	6
7												7
8												8
9	TOTAL Facility Related				$23,524.00		$ 3,961,000	$ 3,745,040			$ 151,441	9
	B. Non-Facility Related*											
10												10
11								Disallow Late Payment Fees			(93)	11
12								Offset Interest Income			(3,250)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,343)	14
15	TOTALS (line 9+line14)						$ 3,961,000	$ 3,745,040			$ 148,098	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 18,923** **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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 105,584	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.)	2013	$ 130,106	2
3. Under or (over) accrual (line 2 minus line 1).		$ 24,522	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 77,168	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.)		$ 6,520	5
	Allocated from Managment Co.	3,441	
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.		$ 111,651	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	127,070	8
	2010	122,091	9
	2011	115,192	10
	2012	102,970	11
	2013	130,106	12

Tax Accrual = 101,690 X 75.89% = 77,168

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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	$ 127,950.04	$ 127,950.04
2.	06-02.0-310-054	Long Term Care Property	$ 2,156.74	$ 2,156.74
3.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 39,795.50	$ 3,441.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 169,902.28	$ 133,547.78

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/14 Ending: 12/31/14

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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 991,012	4
5			2006		55,818	2,030	40	1,431	(599)	12,165	5
6											6
7	Allocated from Management Co.		1995		33,529			958	958	18,829	7
8											8
	Improvement Type**										
9	Various			1994	17,859	268	20	357	89	17,859	9
10	Various			1995	33,623	337	20	1,681	1,344	33,179	10
11	Various			1996	2,178	56	20	109	53	2,034	11
12	Various			1997	9,423		20	471	471	8,247	12
13	Various			1998	4,800	123	20	240	117	3,960	13
14	Various			1999	16,266	93	20	813	720	12,790	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	890	18
19	Fan Motor			2001	1,123		20	56	56	734	19
20	Drywall-Dining Room			2002	10,650		10			10,650	20
21	Door			2002	9,860	184	20	493	309	5,957	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	57,574	26
27	Nursing Station			2003	35,060		20	1,753	1,753	19,867	27
28	Nursing Station			2003	28,692		20	1,435	1,435	17,456	28
29	Nursing Station			2003	6,368		20	318	318	3,528	29
30	Replace Accelerator			2003	968		20	48	48	579	30
31	Sprinkler System			2004	3,610	131	20	181	50	1,897	31
32	Smoke shelter			2004	6,041	220	20	302	82	3,171	32
33	Security System			2005	11,166	406	20	558	152	5,302	33
34	Condensing Unit - 5 Ton			2005	1,959	71	20	98	27	931	34
35	Cabinets and countertops			2005	110,923	4,011	20	5,546	1,535	52,688	35
36	Air Handler			2005	1,549	56	20	78		738	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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)	$ 2,647	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	519	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	1,995	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	2,086	40
41	Sprinkler System - new pipe	2005	1,463	53	20	73	20	694	41
42	Door Alarms	2005	3,587	130	20	179	49	1,703	42
43	Wallpaper	2005	17,835		20	892	892	8,473	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	14,060	44
45	6 Doors	2005	1,926	70	20	96	26	915	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	4,937	46
47	Vinyl Flooring	2005	4,878	244	20	244		2,317	47
48	Duct Heater	2006	1,195	60	20	60		509	48
49	Kitchen Garbage Disposal	2006	1,467	73	20	73		623	49
50	Copper Pipe & Concrete	2006	3,722	186	20	186		1,581	50
51	Fence	2006	6,061	303	20	303		2,576	51
52	Shower Remodel - Hall 400	2006	21,570	1,079	20	1,079		9,168	52
53	Tile Kitchen Floor	2006	9,750	488	20	488		4,145	53
54	Shower Remodel - Hall 200	2006	21,570	1,079	20	1,079		9,168	54
55	Shower Remodel - Hall 500	2006	21,570	1,079	20	1,079		9,168	55
56	Sprinkler System - new pipe	2006	19,579	979	20	979		8,321	56
57	Front Entrance	2006	2,150	108	20	108		915	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	168	20	168		1,428	58
59	3 Ton Condensing Unit	2006	1,729	86	20	86		734	59
60	Compressor-Walk In Freezer	2006	1,784	89	20	89		757	60
61	Air Conditioners (5)	2006	2,146	215	10	215		1,825	61
62	Air Conditioners (6)	2006	2,576	129	20	129		1,096	62
63	Phone System	2006	1,658	83	20	83		705	63
64	Remove & reinstall 6 dry pendents	2007	3,039	111	20	152	41	1,140	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	2,813	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	84	(32)	1,036	66
67	New Window Glass	2007	3,562	130	20	178	48	1,335	67
68	Paving, Parking Lot & Driveway	2007	32,275	2,012	20	113	(1,900)	9,101	68
69	Handrails	2007	2,980		20	149	149	1,118	69
70	TOTAL (lines 4 thru 69)		$ 3,701,524	$ 20,739		$ 102,081	$ 81,321	$ 1,404,613	70

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,701,524	$ 20,739		$ 102,081	$ 81,343	$ 1,404,613	1
2	Fire Damper and Roof Vent	2007	5,114	141	20	256	115	1,918	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790	75	20	440	365	3,297	3
4	Walk In Freezer Door	2008	2,316	116	20	116		869	4
5	Replace 4 Inch Main	2008	3,158	116	20	158	42	1,027	5
6	Sprinkler heads for alarm	2008	29,310	1,466	20	1,466		9,527	6
7	Sign	2009	2,685	134	20	134		873	7
8	Hot Water Heater	2009	5,182	259	20	259	(0)	1,425	8
9	Vinyl Flooring	2009	14,512	726	20	726	0	3,993	9
10	Hot Water Heater	2010	5,094	255	20	255	0	1,402	10
11	Valves	2011	3,310	166	20	166		745	11
12	100 gallon hot water heater	2011	33,232	1,662	20	1,662		5,816	12
13	Security system - Phase 1 & 2	2011	21,394	535	20	1,070	535	3,744	13
14									14
15	Patio	2012	5,848		20	455	455	1,137	15
16	Gazebo	2012	19,098		20	637	637	1,591	16
17									17
18	Duct Heater	2013	3,213		20	161	161	241	18
19	Two Water Heaters & replace 2" main shut off valve &	2013	15,085		20	754	754	1,131	19
20	1 1/2" swing check valve								20
21									21
22	A/C Units	2013	4,380		20	219	219	329	22
23	-Removal of existing outdoor A/C unit								23
24	-Install a new 1 1/2 ton A/C unit and a 4 ton A/C unit								24
25	-Install A new trunk line and insulate with duct liner								25
26	-Install A new liquid line filter drier & pressure test								26
27									27
28	Parking Lot Improvement	2013	54,724		20	2,736	2,736	4,104	28
29	-Update the parking lot by milling butt joints,								29
30	patching failed areas, cleaning, applying a primer coat								30
31	-Installed 1.5' Hot Mix Asphalt Overlay								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,937,968	$ 26,387		$ 113,748	$ 87,362	$ 1,447,782	34

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,937,968	$ 26,387		$ 113,748	$ 87,362	$ 1,447,782	1
2	Basement Remodel	2013	30,088		20	1,504	1,504	2,257	2
3	-Frame walls and exterior concrete								3
4	-Replace electrical can lights and recepticals								4
5	-Add heat register in office								5
6	-Install commercial carpet on floor								6
7	-Replace drywall walls and ceilings								7
8	-Replace 4 windows								8
9	-Add sink and new plumbing								9
10	-Crack in wall repair								10
11									11
12	Fire alarm replacement	2013	17,758		20	888	888	1,332	12
13									13
14	Asphalt and sealcoating - Driveway and 2 Walkways	2014	2,750	1,461	20	69	(1,392)	69	14
15	Remove and replace patio	2014	17,831		20	446	446	446	15
16	New exhaust fan and installation on roof	2014	3,210	93	20	80	(13)	80	16
17	Replace transfer switches - Generator	2014	4,727	79	20	118	39	118	17
18	3 ton air handler & 5 ton air handler & ductwork-Mech Room	2014	3,100		20	78	78	78	18
19	Replace new PVC drain, toilet, sink, sump pump-Office	2014	2,647	68	20	66	(2)	66	19
20									20
21									21
22	Adjustment to Current Book Depreciation			(4,592)			4,592		22
23									23
24	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	3,752		20	9	9	3,752	24
25	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	625		20	31	31	580	25
26	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	724		20	36	36	723	26
27	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	619		20	31	31	519	27
28	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,720		20	86	86	1,297	28
29	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	3,558		20	178	178	1,690	29
30	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	2,014		20	101	101	755	30
31	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	4,205		20	210	210	1,156	31
32	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	2,245		20	112	112	168	32
33	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	2,264		20	57	57	57	33
34	TOTAL (lines 1 thru 33)		$ 4,041,805	$ 23,496		$ 117,848	$ 94,352	$ 1,462,924	34

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 822,496	$ 1,642	$ 19,837	$ 18,195	10	$ 603,383	71
72	Current Year Purchases	3,326	2,024	333	(1,691)	5	333	72
73	Fully Depreciated Assets	165,265					165,265	73
74	Allocated from Mgmt Co	10,816		221	221	10	9,055	74
75	TOTALS	$ 1,001,903	$ 3,666	$ 20,391	$ 16,725		$ 778,036	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2014 Chrysler Town & Country	2014	$ 32,408	$ 17,014	$ 3,241	$ (13,773)	5	$ 3,241	76
77										77
78	Allocated from Mgmt Co	2010 Infinity	2010	5,957		1,191	1,191		5,361	78
79										79
80	TOTALS			$ 38,365	$ 17,014	$ 4,432	$ (12,582)		$ 8,602	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)	$ 5,327,073	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 44,176	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,671	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 98,495	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,249,561	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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Management Co.		$	$ 992	17
18					18
19					19
20					20
21	TOTAL		$	$ 992	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: 01/01/14 Ending: 12/31/14

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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	3,387	$ 243,859	$	3,387	$ 243,859	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,057	98,712		2,057	98,712	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		3,067	196,300		3,067	196,300	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				28,523		28,523	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen						9,333		9,333	12
13	Other (specify):									13
14	TOTAL			$	8,511	$ 538,871	$ 37,856	8,511	$ 576,727	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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 128,011	$ 578,663	1
2	Cash-Patient Deposits	39,053	39,053	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (11,490))	1,855,293	1,855,293	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,722	40,195	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	332,317	676,205	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,379,396	$ 3,189,409	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	3,017,787	14
15	Leasehold Improvements, at Historical Cost	653,049	1,024,018	15
16	Equipment, at Historical Cost	322,085	1,040,268	16
17	Accumulated Depreciation (book methods)	(600,840)	(2,249,561)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Accum Amortization**		37,344	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 445,112	$ 3,114,856	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,824,508	$ 6,304,265	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 59,738	$ 79,722	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,517	39,517	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,159	144,159	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,319	16,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)		77,168	32
33	Accrued Interest Payable		12,421	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	429,253	453,434	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 688,986	$ 822,740	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,745,040	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)**	$	$ 3,745,040	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 688,986	$ 4,567,780	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,135,522	$ 1,736,485	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,824,508	$ 6,304,265	48

*(See instructions.)

Facility Name: **Cahokia Nursing & Rehab Ctr**
IDPH License ID Number: **0039636**
Fiscal Year End: **12/31/14**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Due from State Interest	200	200
Short Term Loan Exchange	238,790	238,790
Note Payable - Stockholders	93,327	93,327
Total - Line 9	**332,317**	**332,317**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due from State	78,936	78,936
Due to State per Audit	10,121	10,121
Reimbursement Due	44,890	44,890
Insurance Premiums Payable	7,614	7,614
Accrued Expenses	297,700	297,700
Due To Cahokia Nursing	-	24,181
Due/From Cahokia Property LLC	(24,181)	(24,181)
Due/From Vacant Cahokia Prop	14,173	14,173
Total - Line 36	**429,253**	**453,434**

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,502,179	1
2	Restatements (describe):		2
3	**Prior period Adjustment**	(285,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,217,179	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	373,344	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	45,000	10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(500,000)	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)**	$ (81,657)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,135,522	24 *

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 6,279,037	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,279,037	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	528,289	6
7	Oxygen	14,344	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 542,633	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***	3,049	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,049	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	2,185	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,185	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,826,904	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,243,333	31
32	Health Care	2,216,437	32
33	General Administration	1,595,310	33
	B. Capital Expense		
34	Ownership	476,269	34
	C. Ancillary Expense		
35	Special Cost Centers	601,929	35
36	Provider Participation Fee	320,282	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,453,560	40
41	**Income before Income Taxes (line 30 minus line 40)****	373,344	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 373,344	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,854,881	44
45	Private Pay - Net Inpatient Revenue	47,387	45
46	Medicare - Net Inpatient Revenue	876,028	46
47	Other-(specify) Hospice	41,427	47
48	Other-(specify) VA	459,314	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,279,037	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: 01/01/14 Ending: 12/31/14

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	2,002	2,080	$ 67,127	$ 32.27	1
2	Assistant Director of Nursing	1,975	2,008	55,713	27.75	2
3	Registered Nurses	4,324	4,421	118,461	26.80	3
4	Licensed Practical Nurses	25,160	26,510	558,738	21.08	4
5	CNAs & Orderlies	85,463	92,527	1,079,904	11.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,991	5,888	94,384	16.03	8
9	Activity Director					9
10	Activity Assistants	6,372	6,923	83,862	12.11	10
11	Social Service Workers	2,715	2,948	41,628	14.12	11
12	Dietician					12
13	Food Service Supervisor	1,712	1,808	32,925	18.21	13
14	Head Cook	877	899	9,305	10.35	14
15	Cook Helpers/Assistants	17,831	19,616	203,038	10.35	15
16	Dishwashers					16
17	Maintenance Workers	3,639	4,089	63,061	15.42	17
18	Housekeepers	19,640	21,561	201,712	9.36	18
19	Laundry	8,281	8,831	80,944	9.17	19
20	Administrator	3,992	4,160	242,802	58.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	14,190	15,198	381,487	25.10	23
24	Clerical	7,110	7,506	154,702	20.61	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 Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	210,274	226,973	$ 3,469,793 *	$ 15.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,501	L1, C3	35
36	Medical Director	Monthly	3,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,543	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	1,102	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)		$ 22,501		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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janice Kalz	Administrator	0	$ 91,928
Robin Suydam	General Manager	0	150,874
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 242,802

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 0
Management Fees	120,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey LLP	Accounting	$ 21,140
HK Payroll Services Co.	Accounting	1,864
Field & Goldberg, LLC	Legal	575
Helper, Broom, Macdonald, Hebran	Legal	3,002
Allen Lefkovitz & Assoc PC	RE Tax Appeal	6,520
Lowenbaum Partnership LLC	Legal	763
Polsinelli Shughart	Legal	715
Michigan Peer Review	MDS Review	2,181
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 36,760

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,874
Unemployment Compensation Insurance	52,827
FICA Taxes	258,769
Employee Health Insurance	56,355
Employee Meals	5,855
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	659
Holiday Expense	957
Employee Life Insurance	(1,705)
TOTAL (agree to Schedule V, line 22, col.8)	$ 427,591

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	$ 6,180
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 83)	1,000
Patient Background Checks	
Miscellaneous Inspections & Licenses	1,870
Miscellaneous Dues & Permits	2,772
Illinois Council on Long Term Care	13,275
Allocated from RE Entity	500
Allocated from Management Co.	210
Less: Public Relations Expense	(4,381)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,426

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,522
Allocated from Management Co.	139
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,661

**See instructions.

Facility Name: **Cahokia Nursing & Rehab Ctr**
IDPH License ID Number: **0039636**
Fiscal Year End: **12/31/14**

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
From Page 21		36,760
	Total (agree to Schedule V, line 19, column 3)	36,760
	Allocated from Management Company Legal Fees	151
	Allocated from Management Company Professional Services	1,311
	Allocated from RE Entity Audit Fees	8,425
	Less : Real estate tax appeal reclassed to real estate tax exp	(6,520)
	Less: Non-Allowable Legal Fees	(1,465)
	Total (agree to Schedule V, line 19, column 8)	38,662

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 & Rehab Ctr # 0039636 Report Period Beginning: 01/01/14 Ending: 12/31/14

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-$8,894**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,051** 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. $ **320,282**
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. $ **5,855** 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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.