

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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>I. IDPH Facility ID Number: <u>0039644</u></p> <p>Facility Name: <u>Caseyville Nursing & Rehabilitation Center</u></p> <p>Address: <u>601 West Lincoln Avenue</u> <u>Caseyville</u> <u>62232</u> Number City Zip Code</p> <p>County: <u>St. Clair</u></p> <p>Telephone Number: <u>(618) 345-3072</u> Fax # <u>(618) 345-3170</u></p> <p>HFS ID Number: <u>363952446001</u></p> <p>Date of Initial License for Current Owners: <u>06/01/94</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/06</u> to <u>12/31/06</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"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One South Wacker Dr, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td></td> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One South Wacker Dr, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>		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
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644 Report Period Beginning: 01/01/06 Ending: 12/31/06

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				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	1,318	1,316	4,169	6,803	8
9	SNF/PED					9
10	ICF	36,171	4,948		41,119	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,489	6,264	4,169	47,922	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.53%

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

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 4,169

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	218,993	16,568	4,020	239,581		239,581		239,581		1
2	Food Purchase		230,036		230,036		230,036	(4,536)	225,500		2
3	Housekeeping	133,942	66,073		200,015		200,015	361	200,376		3
4	Laundry	98,268	40,621		138,889		138,889		138,889		4
5	Heat and Other Utilities			148,638	148,638		148,638	1,751	150,389		5
6	Maintenance	128,742	47,661	7,760	184,163		184,163	1,385	185,548		6
7	Other (specify):*										7
8	TOTAL General Services	579,945	400,959	160,418	1,141,322		1,141,322	(1,039)	1,140,283		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,657,648	24,402	40,467	1,722,517		1,722,517	(570)	1,721,947		10
10a	Therapy			597,347	597,347		597,347		597,347		10a
11	Activities	66,949	7,056		74,005		74,005		74,005		11
12	Social Services	43,334			43,334		43,334		43,334		12
13	CNA Training										13
14	Program Transportation			159	159		159		159		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,767,931	31,458	640,373	2,439,762		2,439,762	(570)	2,439,192		16
	C. General Administration										
17	Administrative	81,429		223,695	305,124		305,124	(196,637)	108,487		17
18	Directors Fees										18
19	Professional Services			74,644	74,644		74,644	12,276	86,920		19
20	Dues, Fees, Subscriptions & Promotions			9,107	9,107		9,107	(2,184)	6,923		20
21	Clerical & General Office Expenses	307,618		24,958	332,576		332,576	64,714	397,290		21
22	Employee Benefits & Payroll Taxes			373,925	373,925		373,925	4,519	378,444		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,718	1,718		1,718	1	1,719		24
25	Other Admin. Staff Transportation			30,078	30,078		30,078	513	30,591		25
26	Insurance-Prop.Liab.Malpractice			17,679	17,679		17,679	5,053	22,732		26
27	Other (specify):* Mgmt Alloc of Benefit							15,450	15,450		27
28	TOTAL General Administration	389,047		755,804	1,144,851		1,144,851	(96,295)	1,048,556		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,736,923	432,417	1,556,595	4,725,935		4,725,935	(97,904)	4,628,031		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center #0039644 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			37,771	37,771		37,771	325,859	363,630			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,377	49,377		49,377	370,183	419,560			32
33	Real Estate Taxes							96,079	96,079			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicles			315	315		315	1,120	1,435			35
36	Other (specify):* Mortgage Insurance							31,411	31,411			36
37	TOTAL Ownership			807,463	807,463		807,463	104,652	912,115			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,464		137,464		137,464		137,464			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Nonallowable Cost			43,388	43,388		43,388	(43,388)				43
44	TOTAL Special Cost Centers		137,464	125,513	262,977		262,977	(43,388)	219,589			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,736,923	569,881	2,489,571	5,796,375		5,796,375	(36,640)	5,759,735			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	33,478	30		9
10	Interest and Other Investment Income	(48,932)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(576)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,900)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,692)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,078)	43		24
25	Fund Raising, Advertising and Promotional	(78)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(41)	43		28
29	Other-Attach Schedule See Pg 5A	(113,635)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (151,454)		\$	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	
		Amount	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)	114,814		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 114,814		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (36,640)		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
		Yes	No	Amount	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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing & Rehabilitation Center

ID# 0039644

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense - Med A	\$ (13,675)	43	1
2	X-Ray Expense - Med A	(9,040)	43	2
3	Dues and Subscriptions	(50)	20	3
4	Non-Allowable Dues	(2,290)	20	4
5	Management Fees	(84,782)	17	5
6	Management Fees	(3,798)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(113,635)		49

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

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	\$	Caseyville Property LLC	100.00%	\$ 4,850	\$ 4,850	1
2	V	26 Insurance		Caseyville Property LLC	100.00%	4,334	4,334	2
3	V	30 Depreciation		Caseyville Property LLC	100.00%	289,194	289,194	3
4	V	32 Interest		Caseyville Property LLC	100.00%	417,922	417,922	4
5	V	32 Interest Income	445	Caseyville Property LLC	100.00%		(445)	5
6	V	33 Real Estate Taxes		Caseyville Property LLC	100.00%	92,605	92,605	6
7	V	34 Rent	720,000	Caseyville Property LLC	100.00%		(720,000)	7
8	V	36 Mortgage Insurance		Caseyville Property LLC	100.00%	31,411	31,411	8
9	V	43 Other		Caseyville Property LLC	100.00%	272	272	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 720,445			\$ 840,588	\$ * 120,143	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehabilitation Center, Inc.

Provider #: 0039644
1/1/2006 to 12/31/2006

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Management Co.	100.00%	\$ 8	\$	8	15
16	V	3 Housekeeping		SW Management Co.	100.00%	361		361	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,751		1,751	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,385		1,385	18
19	V	17 Administrative	163,695	SW Management Co.	100.00%	51,840		(111,855)	19
20	V	19 Professional Services		SW Management Co.	100.00%	9,118		9,118	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	156		156	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	68,819		68,819	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	1		1	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	513		513	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	719		719	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	15,450		15,450	26
27	V	30 Depreciation		SW Management Co.	100.00%	3,187		3,187	27
28	V	32 Interest		SW Management Co.	100.00%	1,638		1,638	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,474		3,474	29
30	V	35 Rent - Equipment & Vehicles		SW Management Co.	100.00%	1,120		1,120	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		\$ 163,695			\$ 159,540	\$ *	(4,155)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 5,118	S & E Medical Supply Co.	100.00%	\$ 4,514	\$ (604)
16	V	3 Housekeeping	1,157	S & E Medical Supply Co.	100.00%	1,157	
17	V	10 Medical Supplies	3,466	S & E Medical Supply Co.	100.00%	2,896	(570)
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		\$ 9,741			\$ 8,567	\$ * (1,174)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	3	7.00	Salary	\$ 11,745	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	3.5	8.75	Salary&Fees	15,313	L17,C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	4.2	9.50	Salary	16,443	L21,C7	3
4											4
5											5
6											6
7	Note : All individuals work in excess of 40 hours per week.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,501		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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	608,840	11	\$ 89	\$ 54,750	\$ 8	1	
2	3	Housekeeping	Bed Days Available	608,840	11	4,018	54,750	361	2	
3	5	Heat and Other Utilities	Bed Days Available	608,840	11	19,472	54,750	1,751	3	
4	6	Maintenance	Bed Days Available	608,840	11	15,398	54,750	1,385	4	
5	19	Professional Services	Bed Days Available	608,840	11	101,398	54,750	9,118	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	608,840	11	1,732	54,750	156	6	
7	21	Clerical & General Office Exp	Bed Days Available	608,840	11	765,293	711,669	68,819	7	
8	24	Travel and Seminar	Bed Days Available	608,840	11	15	54,750	1	8	
9	25	Other Admin. Staff Transport	Bed Days Available	608,840	11	5,704	54,750	513	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	608,840	11	8,000	54,750	719	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	608,840	11	171,812	54,750	15,450	11	
12	32	Interest	Bed Days Available	608,840	11	18,211	54,750	1,638	12	
13	33	Real Estate Taxes	Bed Days Available	608,840	11	38,636	54,750	3,474	13	
14	35	Rent - Equipment & Vehicles	Bed Days Available	608,840	11	12,454	54,750	1,120	14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	43	11	743,036	743,036	3	51,840	17
18									18	
19									19	
20	30	Depreciation	Direct Cost					3,187	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,905,268	\$ 1,454,705	\$ 159,540	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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	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		\$	\$		\$ 4,514	1
2	3	Housekeeping	Direct Cost					1,157	2
3	10	Medical Supplies	Direct Cost					2,896	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				\$	\$		\$ 8,567	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/06 Ending: 12/31/06

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**		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			
A. Directly Facility Related																				
Long-Term																				
1	Heartland Bank		X	Mortgage	\$38,896.00	11/27/01	\$ 6,814,000	\$ 6,260,165	12/1/36	0.0635	\$ 413,138	1								
2												2								
3							Amortization of Mortgage costs				4,784	3								
4												4								
5												5								
Working Capital																				
6	N/P Stockholders	X		Working Capital				546,963	Demand	Variable	49,377	6								
7												7								
8												8								
9	TOTAL Facility Related				\$38,896.00		\$ 6,814,000	\$ 6,807,128			\$ 467,299	9								
B. Non-Facility Related*																				
10							Allocation from Management Co				1,638	10								
11							Related party interest expense net of interest income				(18,145)	11								
12							Interest income offset				(30,787)	12								
13							Interest income offset from Real Estate entity				(445)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (47,739)	14								
15	TOTALS (line 9+line14)						\$ 6,814,000	\$ 6,807,128			\$ 419,560	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,411 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Caseyville Nursing & Rehabilitation Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039644

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 2005 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 2005.

(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>03-07.0-300-005</u>	<u>Long term care property</u>	\$ <u>88,607.42</u>	\$ <u>88,607.42</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>39,720.37</u>	\$ <u>3,474.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>128,327.79</u>	\$ <u>92,081.42</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? YES X NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>2001</u>	<u>\$ 350,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 350,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 5,265,179	\$		\$ 146,726	\$ 146,726	\$ 739,204	4
5										5
6										6
7	Management Allocation	1995		39,396		39	1,126	1,126	13,119	7
8										8
	Improvement Type**									
9	Various		1994	22,302	212	20	1,114	902	13,652	9
10	Various		1995	52,604	107	20	2,629	2,522	30,290	10
11	Various		1996	2,492		20	125	125	1,435	11
12	Various		1997	11,349	43	20	567	524	5,394	12
13	Various		1998	14,511	227	20	726	499	7,021	13
14	Various		1999	83,394	613	20	4,170	3,557	31,339	14
15	Parking Lot		2000	2,830	167	20	142	(25)	897	15
16	Sprinkler System		2000	3,385	87	20	169	82	1,129	16
17	Sprinkler System		2000	5,820	149	20	291	142	1,964	17
18	A/C Repairs		2000	1,018		10	102	102	672	18
19	Ac Repairs		2000	1,102		20	55	55	362	19
20	Draperies		2000	1,052		20	53	53	329	20
21	Carpeting		2000	1,578		20	79	79	527	21
22	Air Handler		2000	1,786		20	89	89	581	22
23	Air Conditioner		2000	1,963		7	280	280	1,184	23
24	Air Handler		2000	1,241		20	62	62	403	24
25	Air Conditioner		2000	1,029		20	51	51	342	25
26	Compressor		2000	1,800		20	90	90	630	26
27	Booster Heater		2000	1,675		20	84	84	588	27
28	Air Conditioner		2000	5,821		20	291	291	1,843	28
29	Air Conditioner		2000	17,320		20	866	866	5,701	29
30	Air Conditioner		2001	3,630		20	182	182	1,029	30
31	Air Conditioner		2001	3,630		20	182	182	1,029	31
32	Air Conditioner		2001	3,111		20	156	156	882	32
33	Blinds		2001	1,212		20	61	61	354	33
34	Sprinkler Repair		2001	1,609		20	80	80	469	34
35	Sprinkler Heads		2001	2,145		20	107	107	608	35
36	Pipes Repair		2001	1,903		20	95	95	483	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Dining Room Wall	2002	\$ 10,650	\$ 191	10	\$ 1,065	\$ 874	\$ 4,970	37
38	Water Heater	2002	4,900		12	408	408	2,008	38
39	Circuit Breaker	2002	1,390		10	139	139	672	39
40	Air Conditioners	2002	2,890		7	413	413	1,824	40
41	Air Conditioners	2002	4,284		7	612	612	2,754	41
42	Water Heater	2002	2,249		12	187	187	781	42
43	Doors	2003	9,995	256	20	500	244	2,000	43
44	Dry Value System	2003	5,623	144	20	281	137	1,007	44
45	Landscaping	2003	8,800	686	20	440	(246)	1,467	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	5,396	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	339	47
48	P.A. Amplifier	2003	713		20	36	36	143	48
49	Security Systems	2004	23,268	901	20	1,163	262	2,909	49
50	16 Transmitters	2004	1,517		20	76	76	190	50
51	Nurses Stations	2004	35,000	1,486	20	1,750	264	4,375	51
52	Wardrobe units w/ Installation	2004	46,731	1,486	20	2,337	851	5,841	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	6,445	53
54	Air Conditioners	2005	20,666	6,613	7	4,133	(2,480)	6,200	54
55	Freezer Door	2005	2,100		20	105	105	158	55
56	Wallpaper	2005	16,140		20	3,228	3,228	4,842	56
57	Sprinkler System	2005	5,545	202	20	277	75	416	57
58	Painting and Wallcovering	2005	38,520		20	7,704	7,704	11,556	58
59	Air Condensers	2005	6,270	228	20	314	86	470	59
60	Vinyl Flooring	2005	5,009	182	20	1,002	820	1,503	60
61	Paving and Sealing Sidewalks	2005	7,000	665	20	467	(198)	700	61
62	Metal Doors	2005	1,926	70	20	96	26	145	62
63	Kitchen Floor	2006	10,300	78	20	258	180	258	63
64	Sprinkler System	2006	9,529	14	20	238	224	238	64
65	Door Monitors & Paging System	2006	811	9	20	20	11	20	65
66	Exterior Security Lighting	2006	4,180	19	20	105	86	105	66
67	6 A/C Units	2006	2,576	2,576	20	64	(2,512)	64	67
68	6 A/C Units	2006	2,576	2,575	20	64	(2,511)	64	68
69	Fuel Pump & Injectors	2006	4,719	7	20	118	111	118	69
70	TOTAL (lines 4 thru 69)		\$ 5,976,396	\$ 23,118		\$ 194,482	\$ 171,364	\$ 933,438	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,976,396	\$ 23,118		\$ 194,482	\$ 171,364	\$ 933,438	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,703	6	20	93	87	93	2
3	Duct Heater	2006	1,349	39	20	34	(5)	33	3
4	Shower Room Remodel (E Hall)	2006	9,210	14	20	230	216	229	4
5									5
6	Allocation from SW management - leasehold improvements	1995	4,203		20	210	210	2,746	6
7	Allocation from SW management - leasehold improvements	1996	734		20	37	37	388	7
8	Allocation from SW management - leasehold improvements	1997	1,057		20	53	53	633	8
9	Allocation from SW management - leasehold improvements	1998	728		20	36	36	318	9
10	Allocation from SW management - leasehold improvements	1999	2,021		20	101	101	716	10
11	Allocation from SW management - leasehold improvements	2005	4,180		20	209	209	313	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	TOTAL (lines 1 thru 33)		\$ 6,003,581	\$ 23,177		\$ 195,485	\$ 172,308	\$ 938,907	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 965,915	\$ 5,174	\$ 166,259	\$ 161,085	10	\$ 869,103	71
72	Current Year Purchases	9,420	9,420	471	(8,949)	10	471	72
73	Fully Depreciated Assets	81,323					81,323	73
74	Allocation from Mgmt. Co.	10,634		360	360	10	10,065	74
75	TOTALS	\$ 1,067,292	\$ 14,594	\$ 167,090	\$ 152,496		\$ 960,962	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Mgmt. Co.	2004 Cadillac	2004	\$ 5,276	\$	\$ 1,055	\$ 1,055	5	\$ 2,638	76
77										77
78										78
79										79
80	TOTALS			\$ 5,276	\$	\$ 1,055	\$ 1,055		\$ 2,638	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)	\$ 7,426,149	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,771	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 363,630	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 325,859	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,902,507	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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:				\$ <u>N/A</u>			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: _____ *

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: \$ 315 Description: Copier : \$315

(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>Allocation from Mgmt. Co.</u>		\$ _____	\$ <u>1,120</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>1,120</u>	21

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	19,262	\$ 240,009	\$	19,262	\$ 240,009	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		7,763	96,723		7,763	96,723	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		20,426	254,514		20,426	254,514	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				137,464		137,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	47,451	\$ 591,246	\$ 137,464	47,451	\$ 728,710	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,000	\$ 162,909	1
2	Cash-Patient Deposits	19,967	19,967	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,438,054	1,438,054	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,666	10,604	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	418,074	541,731	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,881,761	\$ 2,173,265	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,265,179	14
15	Leasehold Improvements, at Historical Cost	435,012	738,402	15
16	Equipment, at Historical Cost	417,847	1,072,568	16
17	Accumulated Depreciation (book methods)	(525,963)	(1,902,507)	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 (specify): <u>See Schedule 17A</u>		143,124	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,896	\$ 5,666,766	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,208,657	\$ 7,840,031	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 479,761	\$ 484,711	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,540	29,540	28
29	Short-Term Notes Payable	546,963	546,963	29
30	Accrued Salaries Payable	142,040	142,040	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,405	15,405	31
32	Accrued Real Estate Taxes(Sch.IX-B)		91,000	32
33	Accrued Interest Payable	2,695	35,773	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	75,829	75,829	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,292,233	\$ 1,421,261	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,260,165	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)	\$	\$ 6,260,165	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,292,233	\$ 7,681,426	46
47	TOTAL EQUITY(page 18, line 24)	\$ 916,424	\$ 158,605	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,208,657	\$ 7,840,031	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Caseyville Nursing & Rehabilitation Center, Inc.
 Provider #: 0039644
 12/31/2006

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve	-	103,672
RE Escrow-Real Estate Tax	-	76,877
Due from State - Interest	14,332	14,332
Employee Payroll Advance	541	541
Reimbursement Due	1,392	1,392
Short Term Loan Exchange	334,922	334,922
Due to Public Aid	9,995	9,995
Due/From Caseyville Prop. LLC	56,892	-
Total Line 9-Other Current Assets (Specify)	418,074	541,731

Other Long-Term Assets (Specify)

Mortgage Costs	-	167,434
Accumulated Amortization	-	(24,310)
Total Line 22-Other Long-Term Assets (specify)	-	143,124

Other Current Liabilities (Specify)

Insurance Premiums Payable	1,271	1,271
Accrued Expenses	74,558	74,558
Total Line 36-Other Current Liabilities (Specify)	75,829	75,829

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 522,605	1
2	Restatements (describe):		2
3	Prior Year Variance	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 522,607	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	393,817	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 393,817	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)	\$ 916,424	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,635,518	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,635,518	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	517,501	6
7	Oxygen	4,336	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 521,837	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***	30,787	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,787	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	2,050	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,050	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,190,192	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,141,322	31
32	Health Care	2,439,762	32
33	General Administration	1,144,851	33
	B. Capital Expense		
34	Ownership	807,463	34
	C. Ancillary Expense		
35	Special Cost Centers	180,852	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,796,375	40
41	Income before Income Taxes (line 30 minus line 40)**	393,817	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 393,817	43

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

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

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

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,874	2,080	\$ 57,846	\$ 27.81	1
2	Assistant Director of Nursing	1,960	2,080	56,139	26.99	2
3	Registered Nurses	3,484	3,764	93,602	24.87	3
4	Licensed Practical Nurses	24,641	26,255	522,605	19.90	4
5	CNAs & Orderlies	84,795	90,227	858,078	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,316	5,973	69,378	11.62	8
9	Activity Director					9
10	Activity Assistants	5,353	5,851	66,949	11.44	10
11	Social Service Workers	3,046	3,364	43,334	12.88	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,160	36,539	16.92	13
14	Head Cook	9,892	11,106	110,489	9.95	14
15	Cook Helpers/Assistants	8,817	9,391	71,965	7.66	15
16	Dishwashers					16
17	Maintenance Workers	7,378	7,961	128,742	16.17	17
18	Housekeepers	16,179	17,442	133,942	7.68	18
19	Laundry	11,744	12,852	98,268	7.65	19
20	Administrator	2,024	2,080	81,429	39.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,027	12,986	307,618	23.69	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)	200,434	215,572	\$ 2,736,923 *	\$ 12.70	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	\$ 4,020	L1, C3	35
36	Medical Director	Monthly	2,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,801	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	6,101	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Physical Rehab</u>	Monthly	32,666	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 52,988		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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Gerri Isenberg	Administrator	0	\$ 81,429	Workers' Compensation Insurance	\$ 57,088	IDPH License Fee	\$ 50	
				Unemployment Compensation Insurance	37,640	Advertising: Employee Recruitment		
				FICA Taxes	209,273	Health Care Worker Background Check	2,991	
				Employee Health Insurance	65,620	(Indicate # of checks performed 250)		
				Employee Meals	3,940	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	4,050	
				Miscellaneous Employee Benefits	4,883	Miscellaneous Dues & Permits	996	
				Employee Relations		Miscellaneous Inspections & Licenses	970	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,429	TOTAL (agree to Schedule V, line 22, col.8)		\$ 378,444	TOTAL (agree to Sch. V, line 20, col. 8)	
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 Management Co-Home Office & Management Fees			\$ 163,695	N/A			Out-of-State Travel	\$
Ronnie Klein-Management Fees			60,000				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 223,695	TOTAL		\$	Seminar Expense	1,718
C. Professional Services							Allocation from Management Co	
Vendor/Payee	Type		Amount				1	
Burroughs, Helper, Broom	Legal		\$ 57,252				Entertainment Expense	
Alan Gray Claims Processing	Legal		1,250				()	
Ashman & Stein	Legal		266				TOTAL (agree to Sch. V, line 24, col. 8)	
Amelung, Wulff & Willenbrock	Legal		515				\$ 1,719	
Personnel Planners, Inc.	Unemployment Consultant		1,212					
RSM McGladrey	Accounting		14,149					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 74,644					

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Caseyville Nursing & Rehabilitation Center, Inc.

Provider # : 0039644

12/31/2006

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	74,644
Allocated from Real Estate Entity - Accounting	4,850
Allocated from Mangement Company	
- Legal	7,512
- Accounting	<u>1,606</u>
Allocated from Mangement Company	9,118
Less : Non-Allowable Legal Costs	(1,692)
Total (Agree to Schedule V, Line 19, Column 8)	<u><u>86,920</u></u>

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 LTC : \$1,760
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 622 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,940 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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 \$2500, 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