

		FOR BHF USE					

LL1

**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.

**I. IDPH Facility ID Number:** 0039651

**Facility Name:** Virgil Calvert Nursing & Rehabilitation Center

**Address:** 5050 Summit Avenue East St. Louis 62205  
 Number City Zip Code

**County:** St. Clair

**Telephone Number:** (618) 874-3597 **Fax #** (618) 874-1812

**HFS ID Number:** 369523260001

**Date of Initial License for Current Owners:** 06/01/94

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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
<b>IRS Exemption Code</b> _____	<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 _____	

**In the event there are further questions about this report, please contact:**  
 Name: Charles J. Fischer Telephone Number: (312) 634-4580  
 Please send copies of desk review and audit adjustments to address on this page.

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____
	(Date) _____
<b>Paid Preparer</b>	(Type or Print Name) _____
	(Title) _____
<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>
	(Date) _____
	(Print Name and Title) _____
	(Firm Name & Address) <u>McGladrey &amp; Pullen LLP</u> <u>One South Wacker Drive, 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651 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	8,189		3,764	11,953	8
9	SNF/PED					9
10	ICF	30,486	47		30,533	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,675	47	3,764	42,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.60%

D. How many bed-hold days during this year were paid by the Department?

0 (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 27 and days of care provided 3,764

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.

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cent # 0039651 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
	<b>A. General Services</b>										
1	Dietary	199,523	12,186	4,098	215,807		215,807		215,807		1
2	Food Purchase		168,684		168,684		168,684	(4,997)	163,687		2
3	Housekeeping	119,410	59,890		179,300		179,300	361	179,661		3
4	Laundry	91,882	25,678		117,560		117,560		117,560		4
5	Heat and Other Utilities			118,901	118,901		118,901	1,751	120,652		5
6	Maintenance	52,366	36,985	9,691	99,042		99,042	1,385	100,427		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	463,181	303,423	132,690	899,294		899,294	(1,500)	897,794		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,357,330	46,290	10,348	1,413,968		1,413,968	478	1,414,446		10
10a	Therapy			387,233	387,233		387,233		387,233		10a
11	Activities	47,267	1,611		48,878		48,878		48,878		11
12	Social Services	48,336			48,336		48,336		48,336		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,452,933	47,901	397,581	1,898,415		1,898,415	478	1,898,893		16
	<b>C. General Administration</b>										
17	Administrative	64,908		255,073	319,981		319,981	(225,828)	94,153		17
18	Directors Fees										18
19	Professional Services			34,947	34,947		34,947	12,307	47,254		19
20	Dues, Fees, Subscriptions & Promotions			7,920	7,920		7,920	(1,633)	6,287		20
21	Clerical & General Office Expenses	132,094		28,229	160,323		160,323	63,041	223,364		21
22	Employee Benefits & Payroll Taxes			290,854	290,854		290,854	2,716	293,570		22
23	Inservice Training & Education										23
24	Travel and Seminar			484	484		484	1	485		24
25	Other Admin. Staff Transportation			3,335	3,335		3,335	513	3,848		25
26	Insurance-Prop.Liab.Malpractice			18,064	18,064		18,064	719	18,783		26
27	Other (specify):* <b>Mgmt Alloc of Benefit</b>							15,450	15,450		27
28	<b>TOTAL General Administration</b>	197,002		638,906	835,908		835,908	(132,714)	703,194		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,113,116	351,324	1,169,177	3,633,617		3,633,617	(133,736)	3,499,881		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.

## 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	
	<b>D. Ownership</b>											
30	Depreciation			39,030	39,030		39,030	246,406	285,436			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,634	80,634		80,634	310,730	391,364			32
33	Real Estate Taxes							192,710	192,710			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicles							1,120	1,120			35
36	Other (specify):* <b>Mortgage Insurance</b>							29,229	29,229			36
37	<b>TOTAL Ownership</b>			839,664	839,664		839,664	60,195	899,859			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,276		75,276		75,276		75,276			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):* <b>Nonallowable Cost</b>			18,467	18,467		18,467	(18,467)				43
44	<b>TOTAL Special Cost Centers</b>		75,276	100,592	175,868		175,868	(18,467)	157,401			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,113,116	426,600	2,109,433	4,649,149		4,649,149	(92,008)	4,557,141			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 Virgil Calvert Nursing & Rehabilitation Center

# 0039651

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	(10,244)	30		9
10	Interest and Other Investment Income	(80,634)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(305)	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	(1,211)	43		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,379)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,287)	43		28
29	Other-Attach Schedule <u>See Page 5A</u>	(108,167)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (208,127)		\$	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)	116,119		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 116,119		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (92,008)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing & Rehabilitation Center

Provider #: 0039651

01/01/06 to 12/31/06

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Disallow Part A Lab	(6,437)	43
Disallow Part A X-ray	(4,159)	43
Offset Misc. Income	(1,980)	21
Non-Allowable Dues	(2,290)	20
Management Fees	(82,595)	17
Management Fees	(3,798)	21
Real Estate Taxes	(6,908)	33
<b>Total</b>	<b><u>(108,167)</u></b>	

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:	
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)	
1	V	19 Professional Services	\$	Virgil Calvert Property LLC	100.00%	\$ 4,400	\$ 4,400	1
2	V	20 Licenses & Fees		Virgil Calvert Property LLC	100.00%	501	501	2
3	V	30 Depreciation		Virgil Calvert Property LLC	100.00%	253,463	253,463	3
4	V	32 Interest Income	456	Virgil Calvert Property LLC	100.00%		(456)	4
5	V	32 Interest		Virgil Calvert Property LLC	100.00%	390,182	390,182	5
6	V	33 Real Estate taxes		Virgil Calvert Property LLC	100.00%	196,144	196,144	6
7	V	34 Rent-Facility & Grounds	720,000	Virgil Calvert Property LLC	100.00%		(720,000)	7
8	V	36 Mortgage Interest		Virgil Calvert Property LLC	100.00%	29,229	29,229	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 720,456			\$ 873,919	\$ * 153,463	14

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

**Virgil Calvert Nursing & Rehabilitation Center**

**Provider #: 0039651**

**12/31/06**

**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
16	V	3 Housekeeping		SW Management Co.	100.00%	361	361
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,751	1,751
18	V	6 Maintenance		SW Management Co.	100.00%	1,385	1,385
19	V	17 Administrative	195,073	SW Management Co.	100.00%	51,840	(143,233)
20	V	19 Professional Services		SW Management Co.	100.00%	9,118	9,118
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	156	156
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	68,819	68,819
23	V	24 Travel and Seminar		SW Management Co.	100.00%	1	1
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	513	513
25	V	26 Insurance-Prop Liab. Malpractice		SW Management Co.	100.00%	719	719
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	15,450	15,450
27	V	30 Depreciation		SW Management Co.	100.00%	3,187	3,187
28	V	32 Interest		SW Management Co.	100.00%	1,638	1,638
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,474	3,474
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,120	1,120
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 195,073			\$ 159,540	\$ * (35,533)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 9,738	S & E Medical Supply Co.	100.00%	\$ 7,449	\$ (2,289)
16	V	3 Housekeeping	77	S & E Medical Supply Co.	100.00%	77	
17	V	10 Medical Supplies	4,016	S & E Medical Supply Co.	100.00%	4,494	478
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		\$ 13,831			\$ 12,020	\$ * (1,811)

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cen # 0039651 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	5.50	See Schedule 7B	4	10.00	Salary&Fees	17,500	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	4.2	10.00	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	\$ 45,688		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 Virgil Calvert Nursing & Rehabilitation Center # 0039651 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 Service	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	17	Administrative	Average Hrs Worked	43	11	743,036	743,036	3	51,840	16
17									17	
18									18	
19	30	Depreciation	Direct Cost					3,187	19	
20									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 Virgil Calvert Nursing & Rehabilitation Center

# 0039651

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 S & E Medical Supply Co.  
 Street Address 3100 Commerical Ave.  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number (847) 982-9300  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		7,449	1
2	3	Housekeeping	Direct Cost					77	2
3	10	Medical Supplies	Direct Cost					4,494	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				\$	\$		12,020	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cent # 0039651 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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Heartland Bank		X	Mortgage	\$23,524.00	11/27/01	\$ 6,359,200	\$ 6,081,532	12/01/36	0.0635	\$ 385,512	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	N/P Stockholder	X		Working Capital				772,532	Demand	Variable	56,380	6								
7	Intercompany Loan	X		Working Capital				373,575	Demand	0.0600	24,254	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$23,524.00		\$ 6,359,200	\$ 7,227,639			\$ 466,146	9								
<b>B. Non-Facility Related*</b>																				
10								Interest Income offset			(456)	10								
11								Amortization of mortgage costs			4,670	11								
12								SW Management Allocation-mortgage			1,638	12								
13								Non-related interest			(80,634)	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (74,782)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 6,359,200	\$ 7,227,639			\$ 391,364	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,229 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 Virgil Calvert Nursing & Rehabilitation Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039651

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>02-21.0-209-023</u>	<u>Long-term care property</u>	\$ <u>182,235.58</u>	\$ <u>182,235.58</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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>221,955.95</u>	\$ <u>185,709.58</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.

**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>\$ 400,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 400,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Virgil Calvert Nursing &amp; Rehabilitation Center

# 0039651

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		\$ 4,801,297	\$	15-40	\$ 132,029	\$ 132,029	\$ 671,147	4
5										5
6	Mgmt. Co.	1995	1995	39,396		39	1,126	1,126	13,119	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1994	30,237	725	20	1,512	787	18,431	9
10	Various		1995	25,180	459	20	1,259	800	14,937	10
11	Various		1996	5,688	244	20	284	40	3,030	11
12	Various		1997	4,115	106	20	206	100	1,991	12
13	Various		1998	4,092		20	205	205	2,013	13
14	Various		1999	27,640		20	1,430	1,430	10,508	14
15	Concrete Work		2000	3,181	82	20	159	77	1,034	15
16	Concrete Work		2000	5,030	129	20	252	123	1,636	16
17	Concrete Work		2000	5,195	133	20	260	127	1,690	17
18	Exhaust Fan		2000	3,820		20	191	191	1,496	18
19	Water Heater		2000	5,300		20	265	265	2,032	19
20	Carpeting		2000	5,400		20	270	270	1,980	20
21	Mechanical Room Volv		2000	1,315		20	66	66	791	21
22	Check Valve		2000	877		20	44	44	528	22
23	Plumbing		2000	1,024		20	51	51	614	23
24	100 Gal. Waterheater		2001	4,642		20	232	232	2,463	24
25	Steamer		2001	2,545		20	127	127	1,349	25
26	Concentrator		2001	2,703		7	386	386	2,187	26
27	Air Conditioner		2001	1,895		20	95	95	1,006	27
28	Fire Protection		2001	6,752		20	338	338	3,584	28
29	Air Conditioner		2001	8,313		20	416	416	4,412	29
30	Sprinkler Heads		2001	3,273		20	164	164	1,738	30
31	Blinds		2001	1,212		20	61	61	645	31
32	Sprinkler System Rep		2001	1,827		20	91	91	973	32
33	Heating Systems Repr		2001	1,269		20	63	63	643	33
34	Dining Room Wall		2002	11,663	209	10	1,166	957	5,442	34
35	Dining Room Wall		2002	8,020	144	10	802	658	3,743	35
36	Air Conditioners		2002	1,659		7	237		1,086	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 &amp; ID Number Virgil Calvert Nursing &amp; Rehabilitation Center

# 0039651

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	Air Conditioners	2002	\$ 2,185	\$	7	\$ 312	\$ 312	\$ 1,430	37
38	Front Door	2003	9,860	253	20	493	240	1,972	38
39	Roof	2003	72,800	1,867	20	3,640	1,773	13,953	39
40	Gutters And Soffits	2003	24,221	621	20	1,211	590	4,440	40
41	Nursing Station	2003	2,901		20	145	145	544	41
42	Nursing Station	2003	13,285		20	664	664	2,491	42
43	Nursing Station	2003	12,188		20	609	609	2,082	43
44	Fire Sprinkler System	2003	2,075		20	104	104	373	44
45	Fire Suppression System	2003	2,030		20	102	102	355	45
46	100 Gl. Water Heater	2003	3,085		20	154	154	617	46
47	Resident Room Casework/counters	2003	7,259		20	363	363	1,331	47
48	Pipe/Dry system	2004	2,472	90	20	124	34	309	48
49	Air Compressor	2004	2,766	66	20	138	72	346	49
50	Condensing unit and evaporator	2004	2,230	90	20	112	22	279	50
51	Concrete removal/new pipe	2004	6,111	248	20	306	58	764	51
52	A/C unit in Laundry System	2004	3,329	121	20	166	45	416	52
53	Sprinkler System	2004	2,056	75	20	103	28	257	53
54	Duct Heater	2005	1,381	50	20	69	19	104	54
55	Freezer Door	2005	2,100	672	20	105	(567)	158	55
56	Wallpaper	2005	14,510	4,643	20	726	(3,918)	1,088	56
57	Water Heaters	2005	5,724	208	20	286	78	429	57
58	Security System	2005	25,534	929	20	1,277	348	1,915	58
59	Compressor	2005	1,090	40	20	55	15	82	59
60	Water Heater	2005	1,490	54	20	75	21	112	60
61	Painting & Wallcovering	2005	38,792	12,413	20	1,940	(10,473)	2,909	61
62	Carpet	2005	3,164	1,435	20	158	(1,277)	237	62
63	Vinyl floor	2005	6,327	182	20	316	134	475	63
64	Doors	2005	1,925	70	20	96	26	144	64
65	Asphalt-parking lot	2005	8,500	808	20	425	(383)	638	65
66	Custom built duct heater	2005	1,704	62	20	85	23	128	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,307,654	\$ 27,228		\$ 158,143	\$ 130,678	\$ 816,621	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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,307,654	\$ 27,228		\$ 158,143	\$ 130,915	\$ 816,621	1
2	Kitchen Floor	2006	10,000	136	20	250	114	250	2
3	A/C Units	2006	2,146	429	20	54	(375)	54	3
4	A/C Units	2006	2,576	515	20	64	(451)	64	4
5	2 Ton A/C Unit	2006	1,208	16	20	30	14	30	5
6	Sprinkler System-Replace Pipes	2006	8,357	89	20	209	120	209	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	SW Management Allocation - leasehold improvements	1995	4,203		20	210	210	2,746	19
20	SW Management Allocation - leasehold improvements	1996	734		20	37	37	388	20
21	SW Management Allocation - leasehold improvements	1997	1,057		20	53	53	633	21
22	SW Management Allocation - leasehold improvements	1998	728		20	36	36	318	22
23	SW Management Allocation - leasehold improvements	1999	2,021		20	101	101	716	23
24	SW Management Allocation - leasehold improvements	2005	4,180		20	209	209	314	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,344,864	\$ 28,413		\$ 159,396	\$ 130,983	\$ 822,343	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	\$ 901,853	\$ 10,617	\$ 124,625	\$ 114,008	10	\$ 653,105	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	66,246					66,246	73
74	SW Management	10,634		360	360	10	10,066	74
75	TOTALS	\$ 978,733	\$ 10,617	\$ 124,985	\$ 114,368		\$ 729,417	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	SW Management Allocation	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)	\$ 6,728,873	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,030	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 285,436	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 246,406	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,554,398	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18	SW Management Allocation			1,120	18
19					19
20					20
21	TOTAL		\$ _____	\$ 1,120	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	9,539	\$ 140,798	\$	9,539	\$ 140,798	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		7,028	103,943		7,028	103,943	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		8,959	132,499		8,959	132,499	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescripts				75,276		75,276	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	<b>TOTAL</b>			\$	25,526	\$ 377,240	\$ 75,276	25,526	\$ 452,516	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 Virgil Calvert Nursing & Rehabilitation Center

# 0039651

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 84,852	\$ 119,258	1
2	Cash-Patient Deposits	27,196	27,196	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	1,270,734	1,270,734	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,667	10,016	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	2,475	215,280	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,389,924	\$ 1,642,484	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		4,552,780	14
15	Leasehold Improvements, at Historical Cost	342,649	792,084	15
16	Equipment, at Historical Cost	324,974	984,009	16
17	Accumulated Depreciation (book methods)	(392,222)	(1,554,398)	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>		139,702	22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 275,401	\$ 5,314,177	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,665,325	\$ 6,956,661	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 130,740	\$ 130,740	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,419	30,419	28
29	Short-Term Notes Payable	1,146,107	1,146,107	29
30	Accrued Salaries Payable	111,067	111,067	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,442	15,442	31
32	Accrued Real Estate Taxes(Sch.IX-B)		199,000	32
33	Accrued Interest Payable	4,217	44,169	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	223,438	223,438	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,661,430	\$ 1,900,382	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,081,532	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,081,532	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,661,430	\$ 7,981,914	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,895	\$ (1,025,253)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,665,325	\$ 6,956,661	48

Virgil Calvert Nursing & Rehabilitation Center  
Provider #: 0039651  
12/31/06

Schedule 17A

XV. BALANCE SHEET -

<u>Other Current Assets (specify):</u>	<u>After</u>	
	<u>Operating</u>	<u>Consolidation</u>
Due from state	2,031	2,031
Employee Payroll Advance	434	434
Reimbursement Due	10	10
Other - escrow	-	212,805
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>2,475</b>	<b>215,280</b>

<u>Other Long-Term Assets (specify):</u>	<u>After</u>	
	<u>Operating</u>	<u>Consolidation</u>
Mortgage Costs	-	163,434
Accumulated Amortization	-	(23,732)
<b>Total Line 22 - Other Long-Term Assets (specify)</b>	<b>-</b>	<b>139,702</b>

<u>Other Current Liabilities (specify):</u>	<u>After</u>	
	<u>Operating</u>	<u>Consolidation</u>
Insurance Premiums Payable	1,271	1,271
Due to Public Aid	423	64,424
Due/from Virgil Property LLC	157,320	423
Other Accrued expenses	64,424	157,320
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b>223,438</b>	<b>223,438</b>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(284,298)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(284,298)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>288,193</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>288,193</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,895</b>	<b>24</b> *

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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,640,519	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,640,519	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	286,997	6
7	Oxygen	7,846	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 294,843	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Income	1,317	28
28a	Uniforms	663	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,980	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,937,342	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	899,294	31
32	Health Care	1,898,415	32
33	General Administration	835,908	33
	<b>B. Capital Expense</b>		
34	Ownership	839,664	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	93,743	35
36	Provider Participation Fee	82,125	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,649,149	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	288,193	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 288,193	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 Virgil Calvert Nursing & Rehabilitation Center

# 0039651

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	1,688	1,736	\$ 49,604	\$ 28.57	1
2	Assistant Director of Nursing	72	80	4,714	58.93	2
3	Registered Nurses	6,506	6,965	162,081	23.27	3
4	Licensed Practical Nurses	21,137	22,304	417,778	18.73	4
5	CNAs & Orderlies	67,886	71,700	664,456	9.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,739	4,046	58,697	14.51	8
9	Activity Director					9
10	Activity Assistants	5,443	5,919	47,267	7.99	10
11	Social Service Workers	3,611	3,903	48,336	12.38	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,132	31,373	14.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,265	19,793	168,150	8.50	15
16	Dishwashers					16
17	Maintenance Workers	3,763	4,036	52,366	12.97	17
18	Housekeepers	13,326	14,361	119,410	8.31	18
19	Laundry	9,835	10,734	91,882	8.56	19
20	Administrator	1,904	2,080	64,908	31.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,776	8,347	132,094	15.83	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)	166,871	178,136	\$ 2,113,116 *	\$ 11.86	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	87	\$ 4,098	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	10,348	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	141	9,993	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	396	\$ 24,439		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ N/A		50
51	Licensed Practical Nurses			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	
<u>Kathleen Crawford</u>	<u>Administrator</u>	<u>0%</u>	<u>\$ 64,908</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 52,571</u>	<u>IDPH License Fee</u>	<u>\$ 120</u>	
				<u>Unemployment Compensation Insurance</u>	<u>42,463</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>161,654</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>32,323</u>	<u>(Indicate # of checks performed <u>106</u>)</u>	<u>1,270</u>	
				<u>Employee Meals</u>	<u>2,716</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Council on Long Term Care</u>	<u>4,340</u>	
				<u>Miscellaneous Employee Benefits/Disability</u>	<u>1,843</u>	<u>Miscellaneous Inspections &amp; Licenses</u>	<u>2,190</u>	
						<u>Allocation from Management Company</u>	<u>156</u>	
						<u>Allocation from Real Estate Entity</u>	<u>501</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 64,908</b>			<u>Less: Non-Allowable Dues</u>	<u>(2,290)</u>	
<b>(List each licensed administrator separately.)</b>						<u>Less: Public Relations Expense</u>	<u>( )</u>	
<b>B. Administrative - Other</b>						<u>Non-allowable advertising</u>	<u>( )</u>	
<b>Description</b>			<b>Amount</b>			<u>Yellow page advertising</u>	<u>( )</u>	
<u>SW Management-Home Office &amp; Management Fees</u>			<u>\$ 195,073</u>					
<u>Ronnie Klein-Management Fees</u>			<u>60,000</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 255,073</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 293,570</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 6,287</b>	
<b>(Attach a copy of any management service agreement)</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
<b>C. Professional Services</b>				<b>Description</b>			<b>Amount</b>	
<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>		<b>Description</b>	<b>Line #</b>	<b>Amount</b>		
<u>Burroughs,Helper,Broom</u>	<u>Legal</u>	<u>\$ 17,001</u>				<u>\$</u>	<u>Out-of-State Travel</u>	
<u>Alan Gray Claims Processing</u>	<u>Legal</u>	<u>625</u>						
<u>Sachnoff &amp; Weaver</u>	<u>Legal</u>	<u>163</u>						
<u>Tueth, Keeney, Cooper, Mohan</u>	<u>Legal</u>	<u>1,200</u>					<u>In-State Travel</u>	
<u>Amelung,Wulff &amp; Willenbrook PC</u>	<u>Legal</u>	<u>147</u>						
<u>RSM McGladrey, Inc.</u>	<u>Accounting</u>	<u>14,149</u>						
<u>Personal Planners</u>	<u>Unemployment Consulting</u>	<u>1,662</u>					<u>Seminar Expense</u>	
							<u>484</u>	
							<u>Allocation from Management Company</u>	
							<u>1</u>	
							<u>Entertainment Expense</u>	
							<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 34,947</b>	<b>TOTAL</b>	<b>\$</b>	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>		
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>						<b>\$ 485</b>		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Virgil Calvert Nursing & Rehabilitation Center**  
**Provider #: 0039651**  
**12/31/06**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	34,947
Out of period legal expenses	(1,211)
Allocated from Virgil Calvert Property LLC:	
Accounting - Reznick Group, .P.C.	4,400
Allocated from SW Management:	
Legal - Stone, McGuire & Benjamin	7,512
Accounting - RSM McGladrey	1,606
Total (agree to Schedule V, line 19, column 8)	<u>47,254</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

**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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center# 0039651Report Period Beginning: 01/01/06Ending: 12/31/06**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 \$2,050
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. \$ 2,716 Has any meal income been offset against related costs? N/A 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? 0  
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 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