

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	1,669	1,479	4,175	7,323	8
9	SNF/PED					9
10	ICF	36,138	4,365		40,503	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,807	5,844	4,175	47,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.35%

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 06/01/1994

J. Was the facility purchased or leased after January 1, 1978? YES Date 06/01/1994 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 4,175

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07
* 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: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	221,663	22,842	3,160	247,665		247,665		247,665	1	
2	Food Purchase		247,549		247,549		247,549	(5,952)	241,597	2	
3	Housekeeping	124,077	59,724		183,801		183,801	163	183,964	3	
4	Laundry	108,840	30,942		139,782		139,782		139,782	4	
5	Heat and Other Utilities			161,180	161,180		161,180	1,501	162,681	5	
6	Maintenance	102,522	42,955	13,467	158,944		158,944	1,933	160,877	6	
7	Other (specify):*									7	
8	TOTAL General Services	557,102	404,012	177,807	1,138,921		1,138,921	(2,355)	1,136,566	8	
B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800	9	
10	Nursing and Medical Records	1,831,711	35,241	15,949	1,882,901		1,882,901	668	1,883,569	10	
10a	Therapy			703,643	703,643		703,643		703,643	10a	
11	Activities	71,178	6,622		77,800		77,800		77,800	11	
12	Social Services	48,099			48,099		48,099		48,099	12	
13	CNA Training									13	
14	Program Transportation			15	15		15		15	14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,950,988	41,863	724,407	2,717,258		2,717,258	668	2,717,926	16	
C. General Administration											
17	Administrative	83,930		157,785	241,715		241,715	(114,361)	127,354	17	
18	Directors Fees									18	
19	Professional Services			44,929	44,929		44,929	12,393	57,322	19	
20	Dues, Fees, Subscriptions & Promotions			13,274	13,274		13,274	(594)	12,680	20	
21	Clerical & General Office Expenses	380,523		32,294	412,817		412,817	36,103	448,920	21	
22	Employee Benefits & Payroll Taxes			378,465	378,465		378,465	4,453	382,918	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			1,078	1,078		1,078	53	1,131	24	
25	Other Admin. Staff Transportation			35,757	35,757		35,757	671	36,428	25	
26	Insurance-Prop.Liab.Malpractice			36,345	36,345		36,345	5,328	41,673	26	
27	Other (specify):*							12,545	12,545	27	
28	TOTAL General Administration	464,453		699,927	1,164,380		1,164,380	(43,409)	1,120,971	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,972,543	445,875	1,602,141	5,020,559		5,020,559	(45,096)	4,975,463	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			21,841	21,841		21,841	192,242	214,083			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,290	32,290		32,290	368,901	401,191			32
33	Real Estate Taxes							104,915	104,915			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicles							1,057	1,057			35
36	Other (specify):*							31,062	31,062			36
37	TOTAL Ownership			774,131	774,131		774,131	(21,823)	752,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			121,187	121,187		121,187		121,187			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):* Non-allowable Cos			29,547	29,547		29,547	(29,547)				43
44	TOTAL Special Cost Centers		121,187	111,672	232,859		232,859	(29,547)	203,312			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,972,543	567,062	2,487,944	6,027,549		6,027,549	(96,466)	5,931,083			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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,857)	30		9
10	Interest and Other Investment Income	(27,090)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(498)	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	(2,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,758)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,368)	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	(446)	43		28
29	Other-Attach Schedule See Pg. 5A	(22,401)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,918)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	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)	(20,548)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (20,548)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (96,466)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Caseville Nursing & Rehabilitation Center

ID# 0039644

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense-Med A	\$ (15,007)	43	1
2	X-Ray Expense-Med A	(6,728)	43	2
3	Association Fees	(666)	20	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(22,401)		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	\$	Caseville Property LLC	100.00%	\$ 6,000	\$	6,000	1
2	V	26 Insurance		Caseville Property LLC	100.00%	4,697		4,697	2
3	V	30 Depreciation		Caseville Property LLC	100.00%	205,342		205,342	3
4	V	32 Interest		Caseville Property LLC	100.00%	399,732		399,732	4
5	V	32 Interest Income	5,200	Caseville Property LLC	100.00%			(5,200)	5
6	V	33 Real Estate Taxes		Caseville Property LLC	100.00%	101,408		101,408	6
7	V	34 Rent	720,000	Caseville Property LLC	100.00%			(720,000)	7
8	V	36 Mortgage Insurance		Caseville Property LLC	100.00%	31,062		31,062	8
9	V	21 Bank Charges		Caseville Property LLC	100.00%	246		246	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 725,200			\$ 748,487	\$ *	23,287	14

* 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	\$	SW Management Co.	100.00%	\$ 27	\$ 27
16	V	3 Housekeeping		SW Management Co.	100.00%	163	163
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,501	1,501
18	V	6 Maintenance		SW Management Co.	100.00%	1,933	1,933
19	V	17 Administrative	157,785	SW Management Co.	100.00%	43,424	(114,361)
20	V	19 Professional Services		SW Management Co.	100.00%	9,151	9,151
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	72	72
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	35,857	35,857
23	V	24 Travel and Seminar		SW Management Co.	100.00%	53	53
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	671	671
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	631	631
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,545	12,545
27	V	30 Depreciation		SW Management Co.	100.00%	2,757	2,757
28	V	32 Interest		SW Management Co.	100.00%	1,459	1,459
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,507	3,507
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,057	1,057
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 157,785			\$ 114,808	\$ * (42,977)

* 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	\$ 6,612	S & E Medical Supply Co.		\$ 5,086	\$ (1,526)	15
16	V	10 Medical Supplies	1,545	S & E Medical Supply Co.		2,213	668	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 8,157			\$ 7,299	\$ *	(858) 39

* 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: 01/01/2007 Ending: 12/31/2007

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	\$ 13,519	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	5	8.75	Salary&Fees	16,386	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	9.50	Salary	13,519	L17, C7	3
4											4
5											5
6											6
7											7
8	Note:All individuals work in excess of 40 hours per week.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,424		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: 01/01/2007 Ending: 2/31/2007

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	11	\$ 319		54,750	\$ 27	1
2	3	Housekeeping	Bed Days Available	11	1,918		54,750	163	2
3	5	Heat and Other Utilities	Bed Days Available	11	17,688		54,750	1,501	3
4	6	Maintenance	Bed Days Available	11	22,780		54,750	1,933	4
5	19	Professional Services	Bed Days Available	11	107,864		54,750	9,151	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	11	844		54,750	72	6
7	21	Clerical & General Office Exp	Bed Days Available	11	422,637	373,471	54,750	35,857	7
8	24	Travel and Seminar	Bed Days Available	11	625		54,750	53	8
9	25	Other Admin. Staff Transport	Bed Days Available	11	7,906		54,750	671	9
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	11	7,442		54,750	631	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	11	147,860		54,750	12,545	11
12	32	Interest	Bed Days Available	11	17,198		54,750	1,459	12
13	33	Real Estate Taxes	Bed Days Available	11	41,339		54,750	3,507	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	11	12,453		54,750	1,057	14
15									15
16									16
17	17	Administrative	Avg. Hours Worked	40	360,500	360,500	3	27,038	17
18		Administrative	Avg. Hours Worked	55	180,250	180,250	5	16,386	18
19									19
20	30	Depreciation	Direct Cost					2,757	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,349,623	\$ 914,221		\$ 114,808	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 5,086	1
2	10	Medical Supplies	Direct Cost					2,213	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 7,299	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 6,188,284	12/1/36	0.0635	\$ 394,948	1								
2												2								
3							Amortization of Mortgage Costs				4,784	3								
4												4								
5												5								
	Working Capital																			
6	N/P Stockholders	X		Working Capital				200,000	Demand	Variable	32,290	6								
7												7								
8												8								
9	TOTAL Facility Related				\$38,896.00		\$ 6,814,000	\$ 6,388,284			\$ 432,022	9								
	B. Non-Facility Related*																			
10							Allocation from Management Co				1,459	10								
11							Related party interest expense net of interest income				(909)	11								
12							Interest income offset				(26,181)	12								
13							Interest income offset from Real Estate Entity				(5,200)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (30,831)	14								
15	TOTALS (line 9+line14)						\$ 6,814,000	\$ 6,388,284			\$ 401,191	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,062 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>94,408.18</u>	\$ <u>94,408.18</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>42,503.98</u>	\$ <u>3,507.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>136,912.16</u>	\$ <u>97,915.18</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

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	Resident Care		2001	\$ 350,000	1
2					2
3	TOTALS			\$ 350,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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
FOR BHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated
Beds*	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation
150	2001		\$ 5,265,180	\$	39	\$ 146,726	\$ 146,726	\$ 885,929
Management Allocation	1995		36,722		39	1,049	1,049	13,278
Improvement Type**								
Various	1994		22,302	212	20	1,115	903	14,766
Various	1995		52,604	107	20	2,630	2,523	32,921
Various	1996		2,492		20	125	125	1,560
Various	1997		11,349	43	20	567	524	5,961
Various	1998		14,511	227	20	726	499	7,747
Various	1999		83,394	613	20	4,170	3,557	35,509
Parking Lot	2000		2,830	167	20	142	(26)	1,039
Sprinkler System	2000		3,385	87	20	169	82	1,298
Sprinkler System	2000		5,820	149	20	291	142	2,255
A/C Repairs	2000		1,018		10	102	102	773
Ac Repairs	2000		1,102		20	55	55	417
Draperies	2000		1,052		20	53	53	382
Carpeting	2000		1,578		20	79	79	606
Air Handler	2000		1,786		20	89	89	670
Air Conditioner	2000		1,963		7	140	140	1,324
Air Handler	2000		1,241		20	62	62	465
Air Conditioner	2000		1,029		20	51	51	393
Compressor	2000		1,800		20	90	90	720
Booster Heater	2000		1,675		20	84	84	671
Air Conditioner	2000		5,821		20	291	291	2,134
Air Conditioner	2000		17,320		20	866	866	6,567
Air Conditioner	2001		3,630		20	182	182	1,211
Air Conditioner	2001		3,630		20	182	182	1,211
Air Conditioner	2001		3,111		20	156	156	1,038
Blinds	2001		1,212		20	61	61	415
Sprinkler Repair	2001		1,609		20	80	80	549
Sprinkler Heads	2001		2,145		20	107	107	715
Pipes Repair	2001		1,903		20	95	95	578

*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:

01/01/2007

Ending:

12/31/2007

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	\$ 6,035	37	
38 Water Heater	2002	4,900		12	408	408	2,416	38	
39 Circuit Breaker	2002	1,390		10	139	139	811	39	
40 Air Conditioners	2002	2,890		7	413	413	2,237	40	
41 Air Conditioners	2002	4,284		7	612	612	3,366	41	
42 Water Heater	2002	2,249		12	187	187	968	42	
43 Doors	2003	9,995	256	20	500	244	2,499	43	
44 Dry Valve System	2003	5,623	144	20	281	137	1,288	44	
45 Landscaping	2003	8,800	618	20	440	(178)	1,907	45	
46 Nursing Stations	2003	35,000		20	1,750	1,750	7,146	46	
47 Repair Fire Protection Equipment	2003	1,694		20	85	85	424	47	
48 P.A. Amplifier	2003	713		20	36	36	179	48	
49 Security Systems	2004	23,268	846	20	1,163	317	4,072	49	
50 16 Transmitters	2004	1,517	55	20	76	21	266	50	
51 Nurses Stations	2004	35,000	1,273	20	1,750	477	6,125	51	
52 Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	8,178	52	
53 Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	10,742	53	
54 Air Conditioners	2005	20,666	3,968	7	4,133	165	10,333	54	
55 Freezer Door	2005	2,100		20	105	105	263	55	
56 Wallpaper	2005	16,140		5	3,228	3,228	8,070	56	
57 Sprinkler System	2005	5,545	202	20	277	75	693	57	
58 Painting and Wallcovering	2005	38,520		5	7,704	7,704	19,260	58	
59 Air Condensers	2005	6,270	228	20	314	86	784	59	
60 Vinyl Flooring	2005	5,009	182	5	1,002	820	2,505	60	
61 Paving and Sealing Sidewalks	2005	7,000	599	15	467	(132)	1,167	61	
62 Metal Doors	2005	1,926	70	20	96	26	241	62	
63 Kitchen Floor	2006	10,300	375	20	515	140	773	63	
64 Sprinkler System	2006	9,529	346	20	476	130	715	64	
65 Door Monitors & Paging System	2006	811	29	20	41	12	61	65	
66 Exterior Security Lighting	2006	4,180	152	20	209	57	314	66	
67 6 A/C Units	2006	2,576	824	20	129	(695)	193	67	
68 6 A/C Units	2006	2,576	824	20	129	(695)	193	68	
69 Fuel Pump & Injectors	2006	4,719	172	20	236	64	354	69	
70 TOTAL (lines 4 thru 69)		\$ 5,973,723	\$ 17,783		\$ 195,132	\$ 177,349	\$ 1,127,677	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	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		
1	Totals from Page 12A, Carried Forward	\$ 5,973,723	\$ 17,783		\$ 195,132	\$ 177,349	\$ 1,127,677		1
2	3 Ton & 1 1/2 Ton A/C Units	3,703	135	20	185	50	278		2
3	Duct Heater	1,349	49	20	67	18	101		3
4	Shower Room Remodel (E Hall)	9,210	335	20	461	126	691		4
5	Demolish and Rebuild Shower Room	57,900	1,463	20	1,448	(16)	1,448		5
6	4 Hot Water Heaters	13,462	364	20	337	(28)	337		6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	39,450	777	20	986	209	986		7
8	Repair Sprinkler System	3,957	66	20	99	33	99		8
9									9
10									10
11									11
12									12
13									13
14									14
15	Allocation from SW management - leasehold improvements	1995 3,918		20	196	196	2,755		15
16	Allocation from SW management - leasehold improvements	1996 684		20	34	34	396		16
17	Allocation from SW management - leasehold improvements	1997 985		20	49	49	639		17
18	Allocation from SW management - leasehold improvements	1998 678		20	34	34	331		18
19	Allocation from SW management - leasehold improvements	1999 1,883		20	94	94	761		19
20	Allocation from SW management - leasehold improvements	2005 3,896		20	195	195	487		20
21	Allocation from SW management - leasehold improvements	2007 2,206		20	55	55	55		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)	\$ 6,117,004	\$ 20,972		\$ 199,371	\$ 178,399	\$ 1,137,040		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	\$ 131,862	\$ 869	\$ 13,324	\$ 12,455	10	\$ 84,322	71
72	Current Year Purchases	6,748		337	337	10	337	72
73	Fully Depreciated Assets	924,795					924,795	73
74	Allocation from Management Co.	9,907		67	67	10	8,344	74
75	TOTALS	\$ 1,073,312	\$ 869	\$ 13,728	\$ 12,859		\$ 1,017,798	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 Management	2004 Cadillac	2004	\$ 4,915	\$	\$ 983	\$ 983	5	\$ 3,441	76
77										77
78										78
79										79
80	TOTALS			\$ 4,915	\$	\$ 983	\$ 983		\$ 3,441	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)	\$ 7,545,231	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,841	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 214,083	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 192,242	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,158,278	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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocation from Management Co.</u>		\$	\$ <u>1,057</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,057</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. /2008 \$ _____

13. /2009 \$ _____

14. /2010 \$ _____

* 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

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? <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			
	1	2	3	4
	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.)

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	9,740	\$ 273,405	\$	9,740	\$ 273,405	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,080	121,831		2,080	121,831	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		11,537	299,961		11,537	299,961	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				121,187		121,187	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			\$	23,357	\$ 695,197	\$ 121,187	23,357	\$ 816,384	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

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	\$ 252,157	1
2 Cash-Patient Deposits	23,132	23,132	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,500,152	1,500,152	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	4,664	10,738	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <u>See Schedule 17A</u>	250,109	304,986	9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,779,057	\$ 2,091,165	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 Cos	549,781	851,825	15
16 Equipment, at Historical Cost	424,594	1,078,227	16
17 Accumulated Depreciation (book methods)	(547,804)	(2,158,278)	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>)		138,340	22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 426,571	\$ 5,525,293	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,205,628	\$ 7,616,458	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 192,970	\$ 199,070	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	36,029	36,029	28
29 Short-Term Notes Payable	200,000	200,000	29
30 Accrued Salaries Payable	162,113	162,113	30
31 Accrued Taxes Payable (excluding real estate taxes)	16,203	16,203	31
32 Accrued Real Estate Taxes(Sch.IX-B)		98,000	32
33 Accrued Interest Payable		33,427	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>See Schedule 17A</u>	132,667	132,667	36
37 <u>See Schedule 17A</u>	71,893		37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 811,875	\$ 877,509	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		6,188,284	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,188,284	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 811,875	\$ 7,065,793	46
47 TOTAL EQUITY (page 18, line 24)	\$ 1,393,753	\$ 550,665	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,205,628	\$ 7,616,458	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Caseyville Nursing & Rehabilitation Center, Inc.

Provider #: 0039644

12/31/2007

XV. BALANCE SHEET -

Other Current Assets (Specify) :	After	
	Operating	Consolidation
RE Replacement Reserve	-	10,425
RE Escrow-Real Estate Tax	-	44,452
Due from State - Interest	14,758	14,758
Employee Loans	14,000	14,000
Short Term Loan Exchange	203,204	203,204
Due to Public Aid	18,147	18,147
Total Line 9-Other Current Assets (Specify)	250,109	304,986

Other Long-Term Assets (Specify)

Capitalized Costs	-	167,434
Accumulated Amortization	-	(29,094)
Total Line 22-Other Long-Term Assets (specify)	-	138,340

Other Current Liabilities (Specify)

Acc. Retirement (From P/R)	600	600
Accrued Expenses	132,067	132,067
Total Line 36-Other Current Liabilities (Specify)	132,667	132,667

Due/From Caseyville Prop. LLC	71,893	-
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Total Line 37-Other Current Liabilities (Specify)	71,893	-
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SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 916,424	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 916,424	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	477,326	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 477,329	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,393,753	24 *

* 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	\$ 5,757,561	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,757,561	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	718,778	6
7	Oxygen	2,430	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 721,208	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 Radic		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***	26,181	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,181	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Income</u>	(75)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (75)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,504,875	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,138,921	31
32	Health Care	2,717,258	32
33	General Administration	1,164,380	33
B. Capital Expense			
34	Ownership	774,131	34
C. Ancillary Expense			
35	Special Cost Centers	150,734	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)*	\$ 6,027,549	40
41	Income before Income Taxes (line 30 minus line 40)**	477,326	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 477,326	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 Caseville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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	1,864	2,080	\$ 59,899	\$ 28.80	1
2	Assistant Director of Nursing	1,928	2,080	53,968	25.95	2
3	Registered Nurses	4,055	4,318	108,077	25.03	3
4	Licensed Practical Nurses	24,387	26,072	523,957	20.10	4
5	CNAs & Orderlies	92,030	98,146	978,766	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,956	8,755	107,044	12.23	8
9	Activity Director					9
10	Activity Assistants	5,363	6,003	71,178	11.86	10
11	Social Service Workers	3,319	3,585	48,099	13.42	11
12	Dietician					12
13	Food Service Supervisor	1,922	2,160	37,426	17.33	13
14	Head Cook	9,525	10,488	105,559	10.06	14
15	Cook Helpers/Assistants	9,163	9,742	78,678	8.08	15
16	Dishwashers					16
17	Maintenance Workers	6,391	7,074	102,522	14.49	17
18	Housekeepers	14,023	15,311	124,077	8.10	18
19	Laundry	12,910	14,157	108,840	7.69	19
20	Administrator	1,904	2,080	83,930	40.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,517	14,704	380,523	25.88	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)	210,257	226,755	\$ 2,972,543 *	\$ 13.11	34

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	\$ 3,160	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,971	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	8,446	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	8,978	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,355		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

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

** See instructions.

Caseyville Nursing & Rehabilitation Center, Inc.

Provider # : 0039644

12/31/2007

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	44,929
Allocated from Real Estate Entity - Accounting	6,000
Allocated from Mangement Company	
- Legal	6,672
- Accounting	<u>2,479</u>
Allocated from Mangement Company	9,151
Less : Non-Allowable Legal Costs	(2,758)
Total (Agree to Schedule V, Line 19, Column 8)	<u><u>57,322</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	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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13												
14												
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17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. IL Council on Long Term Care = \$8,109
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 328 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.
- (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 benefit on Schedule V. \$ 4,453 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 \$5,000, have legal invoices and a summary of service performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT