



Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

# 0039644 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	54,900	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	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	1,536	1,188	3,309	6,033	8
9	SNF/PED					9
10	ICF	33,711	4,786	15	38,512	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,247	5,974	3,324	44,545	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.14%

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 3,309

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	234,557	18,789	4,224	257,570		257,570		257,570		1
2	Food Purchase		258,097		258,097		258,097	(8,596)	249,501		2
3	Housekeeping	109,075	56,980		166,055		166,055	120	166,175		3
4	Laundry	123,599	19,833		143,432		143,432		143,432		4
5	Heat and Other Utilities			182,934	182,934		182,934	1,174	184,108		5
6	Maintenance	86,711	45,269	9,057	141,037		141,037	2,590	143,627		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	553,942	398,968	196,215	1,149,125		1,149,125	(4,712)	1,144,413		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,809,673	44,678	6,284	1,860,635		1,860,635	2,298	1,862,933		10
10a	Therapy			655,459	655,459		655,459		655,459		10a
11	Activities	71,567	6,176		77,743		77,743		77,743		11
12	Social Services	51,346			51,346		51,346		51,346		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,932,586	50,854	666,543	2,649,983		2,649,983	2,298	2,652,281		16
	<b>C. General Administration</b>										
17	Administrative	79,772		157,785	237,557		237,557	(111,385)	126,172		17
18	Directors Fees										18
19	Professional Services			26,684	26,684		26,684	9,722	36,406		19
20	Dues, Fees, Subscriptions & Promotions			7,809	7,809		7,809	(3,568)	4,241		20
21	Clerical & General Office Expenses	448,824		18,687	467,511		467,511	36,455	503,966		21
22	Employee Benefits & Payroll Taxes			394,206	394,206		394,206	5,083	399,289		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,959	1,959		1,959	(437)	1,522		24
25	Other Admin. Staff Transportation			40,844	40,844		40,844	1,189	42,033		25
26	Insurance-Prop.Liab.Malpractice			16,651	16,651		16,651	17,866	34,517		26
27	Other (specify):* <b>Mgmt. Alloc of Benefi</b>							14,891	14,891		27
28	<b>TOTAL General Administration</b>	528,596		664,625	1,193,221		1,193,221	(30,184)	1,163,037		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,015,124	449,822	1,527,383	4,992,329		4,992,329	(32,598)	4,959,731		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.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

#0039644

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			54,455	54,455		54,455	162,945	217,400			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,836	15,836		15,836	378,747	394,583			32
33	Real Estate Taxes							100,609	100,609			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicles							1,041	1,041			35
36	Other (specify):* <b>Mortgage Insurance</b>							36,664	36,664			36
37	<b>TOTAL Ownership</b>			790,291	790,291		790,291	(39,994)	750,297			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,566		174,566		174,566		174,566			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):* <b>Non-allowable cost</b>			35,397	35,397		35,397	(35,397)				43
44	<b>TOTAL Special Cost Centers</b>		174,566	117,747	292,313		292,313	(35,397)	256,916			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,015,124	624,388	2,435,421	6,074,933		6,074,933	(107,989)	5,966,944			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	(40,655)	30		9
10	Interest and Other Investment Income	(15,778)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(488)	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	(2,072)	43		18
19	Entertainment				19
20	Contributions	(474)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(642)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,228)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,653)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(28,607)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (96,597)</b>		<b>\$</b>	<b>30</b>

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)	(11,392)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (11,392)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (107,989)</b>		<b>37</b>

\*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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing & Rehabilitation Center

ID# 0039644

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense-Med A	\$ (15,240)	43	1
2	X-Ray Expense-Med A	(9,242)	43	2
3	Association Fees	(3,825)	20	3
4	Education & Seminar	(300)	24	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(28,607)		49

**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	\$	Caseyville Property LLC	100.00%	\$ 6,500	\$ 6,500	1
2	V	26 Insurance		Caseyville Property LLC	100.00%	17,304	17,304	2
3	V	30 Depreciation		Caseyville Property LLC	100.00%	200,750	200,750	3
4	V	32 Interest		Caseyville Property LLC	100.00%	389,799	389,799	4
5	V	32 Interest Income	58	Caseyville Property LLC	100.00%		(58)	5
6	V	33 Real Estate Taxes		Caseyville Property LLC	100.00%	97,110	97,110	6
7	V	34 Rent	720,000	Caseyville Property LLC	100.00%		(720,000)	7
8	V	36 Mortgage Insurance		Caseyville Property LLC	100.00%	36,664	36,664	8
9	V	32 Amortization		Caseyville Property LLC	100.00%	4,784	4,784	9
10	V	21 Miscellaneous Income	3,402	Caseyville Property LLC	100.00%		(3,402)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 723,460			\$ 752,911	\$ * 29,451	14

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

Caseyville Nursing and Rehabilitation Center, Inc.

Provider #: 0039644

1/1/2008 to 12/31/2008

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:

Beauvais Manor Healthcare and Rehab	St. Louis, MO
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%	120	120
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,174	1,174
18	V	6 Maintenance		SW Management Co.	100.00%	2,590	2,590
19	V	17 Administrative	157,785	SW Management Co.	100.00%	46,400	(111,385)
20	V	19 Professional Services		SW Management Co.	100.00%	3,864	3,864
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	107	107
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	39,857	39,857
23	V	24 Travel and Seminar		SW Management Co.	100.00%	13	13
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	1,189	1,189
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	562	562
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	14,891	14,891
27	V	30 Depreciation		SW Management Co.	100.00%	2,850	2,850
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,499	3,499
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,041	1,041
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 157,785			\$ 118,165	\$ * (39,620)

\* 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	\$ 12,010	S & E Medical Supply Co.	100.00%	\$ 8,489	\$ (3,521)
16	V	10 Medical Supplies	782	S & E Medical Supply Co.	100.00%	3,080	2,298
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 12,792			\$ 11,569	\$ * (1,223)

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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	7.50	Salary	\$ 13,920	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	5	10.00	Salary&Fees	18,560	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	7.50	Salary	13,920	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	\$ 46,400		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: 01/01/2008 Ending: 12/31/2008

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	657,492	12	\$ 98	\$ 54,900	\$ 8	1	
2	3	Housekeeping	Bed Days Available	657,492	12	1,440	54,900	120	2	
3	5	Heat and Other Utilities	Bed Days Available	657,492	12	14,061	54,900	1,174	3	
4	6	Maintenance	Bed Days Available	657,492	12	31,014	54,900	2,590	4	
5	19	Professional Services	Bed Days Available	657,492	12	46,281	54,900	3,864	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,492	12	1,278	54,900	107	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,492	12	477,338	410,633	39,857	7	
8	24	Travel and Seminar	Bed Days Available	657,492	12	157	54,900	13	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,492	12	14,238	54,900	1,189	9	
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	657,492	12	6,729	54,900	562	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,492	12	178,342	54,900	14,891	11	
12	33	Real Estate Taxes	Bed Days Available	657,492	12	41,904	54,900	3,499	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,492	12	12,467	54,900	1,041	13	
14									14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	40	11	371,200	371,200	3	27,840	17
18		Administrative	Avg. Hours Worked	50	6	185,600	185,600	5	18,560	18
19									19	
20	30	Depreciation	Direct Cost					2,850	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 118,165	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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		\$	\$		\$ 8,489	1
2	10	Medical Supplies	Direct Cost					3,080	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				\$	\$		11,569	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center# 0039644

Report Period Beginning:

01/01/2008

Ending:

12/31/2008**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Heartland Bank		X	Mortgage	\$38,896.00	11/27/01	\$ 6,814,000	\$ 6,102,530	12/1/36	0.0635	\$ 389,799	1						
2												2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6	N/P Stockholders	X		Working Capital		7/31/07		225,000	8/5/13	Variable	15,836	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$38,896.00		\$ 6,814,000	\$ 6,327,530			\$ 410,419	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (15,836)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 6,814,000	\$ 6,327,530			\$ 394,583	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 36,664 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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>98,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	<b>96,110</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,890)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>99,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Allocation from Management Company</b>			<b>3,499</b>	
<b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>100,609</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>77,291</b>	8
	2004	<b>84,745</b>	9
	2005	<b>88,605</b>	10
	2006	<b>94,408</b>	11
	2007	<b>96,110</b>	12

**2008 Tax Accrual = 96,110 X 1.03 = 98,993. Use 99,000.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>96,110.20</u>	\$ <u>96,110.20</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>43,500.34</u>	\$ <u>3,499.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>139,610.54</u>	\$ <u>99,609.20</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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	<u>Resident Care</u>		<u>2001</u>	<u>\$ 350,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 350,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Caseyville Nursing &amp; Rehabilitation Center

# 0039644

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	2001		\$ 5,265,180	\$	39	\$ 146,726	\$ 146,726	\$ 1,032,655	4
5										5
6										6
7	Management Allocation	1995		36,141		39	1,033	1,033	13,068	7
8										8
	<b>Improvement Type**</b>									
9	Various		1994	22,302	212	20	1,116	904	18,761	9
10	Various		1995	52,604	107	20	2,630	2,523	35,551	10
11	Various		1996	2,492		20	125	125	1,685	11
12	Various		1997	11,349	43	20	567	524	6,528	12
13	Various		1998	14,511	227	20	726	499	8,473	13
14	Various		1999	83,394	613	20	4,170	3,557	39,679	14
15	Parking Lot		2000	2,830	167	20	142	(26)	1,181	15
16	Sprinkler System		2000	3,385	87	20	169	82	1,467	16
17	Sprinkler System		2000	5,820	149	20	291	142	2,546	17
18	A/C Repairs		2000	1,018		10	102	102	875	18
19	Ac Repairs		2000	1,102		20	55	55	472	19
20	Draperies		2000	1,052		20	53	53	435	20
21	Carpeting		2000	1,578		20	79	79	685	21
22	Air Handler		2000	1,786		20	89	89	759	22
23	Air Conditioner		2000	1,963		7			1,324	23
24	Air Handler		2000	1,241		20	62	62	527	24
25	Air Conditioner		2000	1,029		20	51	51	444	25
26	Compressor		2000	1,800		20	90	90	810	26
27	Booster Heater		2000	1,675		20	84	84	755	27
28	Air Conditioner		2000	5,821		20	291	291	2,425	28
29	Air Conditioner		2000	17,320		20	866	866	7,433	29
30	Air Conditioner		2001	3,630		20	182	182	1,393	30
31	Air Conditioner		2001	3,630		20	182	182	1,393	31
32	Air Conditioner		2001	3,111		20	156	156	1,194	32
33	Blinds		2001	1,212		20	61	61	476	33
34	Sprinkler Repair		2001	1,609		20	80	80	629	34
35	Sprinkler Heads		2001	2,145		20	107	107	822	35
36	Pipes Repair		2001	1,903		20	95	95	673	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 Caseyville Nursing &amp; Rehabilitation Center

# 0039644

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## 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	\$ 7,100	37
38	Water Heater	2002	4,900		12	408	408	2,824	38
39	Circuit Breaker	2002	1,390		10	139	139	950	39
40	Air Conditioners	2002	2,890		7	413	413	2,650	40
41	Air Conditioners	2002	4,284		7	612	612	3,978	41
42	Water Heater	2002	2,249		12	187	187	1,155	42
43	Doors	2003	9,995	256	20	500	244	2,999	43
44	Dry Value System	2003	5,623	144	20	281	137	1,569	44
45	Landscaping	2003	8,800	556	20	440	(116)	2,347	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	8,896	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	509	47
48	P.A. Amplifier	2003	713		20	36	36	215	48
49	Security Systems	2004	23,268	846	20	1,163	317	5,235	49
50	16 Transmitters	2004	1,517	55	20	76	21	329	50
51	Nurses Stations	2004	35,000	1,273	20	1,750	477	7,875	51
52	Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	10,515	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	15,039	53
54	Air Conditioners	2005	20,666	2,381	7	4,133	1,752	14,466	54
55	Freezer Door	2005	2,100		20	105	105	368	55
56	Wallpaper	2005	16,140		5	3,228	3,228	11,298	56
57	Sprinkler System	2005	5,545	202	20	277	75	970	57
58	Painting and Wallcovering	2005	38,520		5	7,704	7,704	26,964	58
59	Air Condensers	2005	6,270	228	20	314	86	1,098	59
60	Vinyl Flooring	2005	5,009	182	5	1,002	820	3,507	60
61	Paving and Sealing Sidewalks	2005	7,000	539	15	467	(72)	1,634	61
62	Metal Doors	2005	1,926	70	20	96	26	337	62
63	Kitchen Floor	2006	10,300	375	20	515	140	1,288	63
64	Sprinkler System	2006	9,529	346	20	476	130	1,191	64
65	Door Monitors & Paging System	2006	811	29	20	41	12	102	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	523	66
67	6 A/C Units	2006	2,576	494	20	129	(365)	322	67
68	6 A/C Units	2006	2,576	495	20	129	(366)	322	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	590	69
70	TOTAL (lines 4 thru 69)		\$ 5,973,142	\$ 15,415		\$ 194,977	\$ 179,562	\$ 1,324,280	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Caseyville Nursing &amp; Rehabilitation Center

# 0039644

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,973,142	\$ 15,415		\$ 194,977	\$ 179,562	\$ 1,324,280	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	463	2
3	Duct Heater	2006	1,349	49	20	67	18	168	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	1,152	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,105	20	2,895	790	1,473	5
6	4 Hot Water Heaters	2007	13,462	490	20	673	183	1,010	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	2,959	7
8	Repair Sprinkler System	2007	3,957	144	20	198	54	297	8
9	Oak flooring	2008	15,571	354	20	389	35	389	9
10	Fire alarm system	2008	8,858	201	20	221	20	221	10
11	Street and parking lot paving	2008	43,360	22,764	20	1,084	(21,680)	1,084	11
12	Replace 3 inch main	2008	4,716	93	20	118	25	118	12
13	Replace hot water pipes	2008	39,504	299	20	988	689	988	13
14									14
15									15
16	Allocation from SW management - leasehold improvements	1995	3,855		20	191	191	2,905	16
17	Allocation from SW management - leasehold improvements	1996	673		20	34	34	423	17
18	Allocation from SW management - leasehold improvements	1997	970		20	49	49	677	18
19	Allocation from SW management - leasehold improvements	1998	668		20	33	33	359	19
20	Allocation from SW management - leasehold improvements	1999	1,854		20	93	93	842	20
21	Allocation from SW management - leasehold improvements	2005	3,835		20	192	192	671	21
22	Allocation from SW management - leasehold improvements	2007	2,171		20	109	109	163	22
23									23
24									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>		\$ 6,228,207	\$ 43,818		\$ 204,929	\$ 161,111	\$ 1,340,641	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	\$ 961,901	\$ 3,412	\$ 10,994	\$ 7,582	10	\$ 874,047	71
72	Current Year Purchases	7,225	7,225	361	(6,864)	10	361	72
73	Fully Depreciated Assets	101,504					101,504	73
74	Allocation from Management Co.	11,412		148	148	10	8,364	74
75	TOTALS	\$ 1,082,042	\$ 10,637	\$ 11,503	\$ 866		\$ 984,276	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	Cadillac	2004	\$ 4,840	\$	\$ 968	\$ 968	5	\$ 4,356	76
77										77
78										78
79										79
80	TOTALS			\$ 4,840	\$	\$ 968	\$ 968		\$ 4,356	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)	\$ 7,665,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,455	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 217,400	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 162,945	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,329,273	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:				\$ <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>1,041</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,041</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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

\* 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>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	\$	4,998	\$ 279,901	\$	4,998	\$ 279,901	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,905	114,328		1,905	114,328	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,892	254,373		4,892	254,373	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				174,566		174,566	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	11,795	\$ 648,602	\$ 174,566	11,795	\$ 823,168	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

# 0039644

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 1,000	\$ 319,378	1
2	Cash-Patient Deposits	28,653	28,653	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000 )	1,674,533	1,746,426	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,791	9,989	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch. 17A	56,285	166,406	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,765,262	\$ 2,270,852	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,265,179	14
15	Leasehold Improvements, at Historical Cost	661,789	963,028	15
16	Equipment, at Historical Cost	431,819	1,086,882	16
17	Accumulated Depreciation (book methods)	(613,916)	(2,329,273)	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): See Sch. 17A		133,556	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 479,692	\$ 5,469,372	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,244,954	\$ 7,740,224	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 6,416	\$ 12,916	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,860	37,860	28
29	Short-Term Notes Payable	225,000	225,000	29
30	Accrued Salaries Payable	63,878	63,878	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,615	9,615	31
32	Accrued Real Estate Taxes(Sch.IX-B)		99,000	32
33	Accrued Interest Payable		32,327	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Sch. 17A	225,267	225,267	36
37	See Sch. 17A	88,321	88,321	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 656,357	\$ 794,184	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,102,530	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>	\$	\$ 6,102,530	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 656,357	\$ 6,896,714	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,588,597	\$ 843,510	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,244,954	\$ 7,740,224	48

Caseyville Nursing & Rehabilitation Center, Inc.  
Provider #: 0039644  
12/31/2007

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	After	
	Operating	Consolidation
RE Replacement Reserve	-	34,543
RE Escrow-Real Estate Tax	-	75,578
Due from State - Interest	9,480	9,480
Employee Loans	11,414	11,414
Reimbursement Due	(169,225)	(169,225)
Short Term Loan Exchange	204,583	204,583
Due to Public Aid	33	33
<b>Total Line 9-Other Current Assets (Specify)</b>	<b>56,285</b>	<b>166,406</b>

Other Long-Term Assets (Specify)

Capitalized Costs	-	167,434
Accumulated Amortization	-	(33,878)
<b>Total Line 22-Other Long-Term Assets (specify)</b>	<b>-</b>	<b>133,556</b>

Other Current Liabilities (Specify)

Insurance Premiums Payable	7,282	7,282
Acc. Retirement (From P/R)	-	-
Accrued Expenses	217,985	217,985
<b>Total Line 36-Other Current Liabilities (Specify)</b>	<b>225,267</b>	<b>225,267</b>

Due/From Caseyville Prop. LLC	88,321	88,321
<b>Total Line 37-Other Current Liabilities (Specify)</b>	<b>88,321</b>	<b>88,321</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,393,753</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>(11,657)</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>1,382,096</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>206,501</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>206,501</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>1,588,597</b>	<b>24</b> *

\* 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	\$ 5,531,280	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,531,280	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	736,070	6
7	Oxygen	4,748	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 740,818	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	1,770	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>	\$ 1,770	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	7,566	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,566	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,281,434	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,149,125	31
32	Health Care	2,649,983	32
33	General Administration	1,193,221	33
	<b>B. Capital Expense</b>		
34	Ownership	790,291	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	209,963	35
36	Provider Participation Fee	82,350	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,074,933	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	206,501	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 206,501	43

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

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

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

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

# 0039644

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	1,992	2,160	\$ 62,477	\$ 28.92	1
2	Assistant Director of Nursing	1,835	2,000	52,054	26.03	2
3	Registered Nurses	2,344	2,508	62,746	25.02	3
4	Licensed Practical Nurses	26,826	28,768	581,237	20.20	4
5	CNAs & Orderlies	92,391	97,377	939,810	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,476	9,320	111,349	11.95	8
9	Activity Director					9
10	Activity Assistants	5,595	6,150	71,567	11.64	10
11	Social Service Workers	3,591	3,817	51,346	13.45	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,200	37,941	17.25	13
14	Head Cook	9,493	10,443	106,079	10.16	14
15	Cook Helpers/Assistants	10,323	11,074	90,537	8.18	15
16	Dishwashers					16
17	Maintenance Workers	5,709	6,205	86,711	13.97	17
18	Housekeepers	11,446	12,525	109,075	8.71	18
19	Laundry	15,186	16,132	123,599	7.66	19
20	Administrator	2,064	2,160	79,772	36.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,580	17,105	448,824	26.24	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)	214,787	229,944	\$ 3,015,124 *	\$ 13.11	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 4,224	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	6,284	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	6,857	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)		\$ 22,165		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Gerri Isenberg</u>	<u>Administrator</u>	<u>0</u>	\$ <u>79,772</u>	<u>Workers' Compensation Insurance</u>	\$ <u>59,501</u>	<u>IDPH License Fee</u>	\$ _____	
_____	_____	_____	_____	<u>Unemployment Compensation Insurance</u>	<u>40,905</u>	<u>Advertising: Employee Recruitment</u>	_____	
_____	_____	_____	_____	<u>FICA Taxes</u>	<u>230,480</u>	<u>Health Care Worker Background Check</u>	_____	
_____	_____	_____	_____	<u>Employee Health Insurance</u>	<u>62,415</u>	<u>(Indicate # of checks performed <u>215</u>)</u>	<u>1,264</u>	
_____	_____	_____	_____	<u>Employee Meals</u>	<u>5,083</u>	<u>Patient Background Checks</u>	_____	
_____	_____	_____	_____	<u>Illinois Municipal Retirement Fund (IMRF)*</u>	_____	<u>Illinois Council on Long Term Care</u>	<u>5,250</u>	
_____	_____	_____	_____	<u>Miscellaneous Employee Benefits</u>	<u>905</u>	<u>Miscellaneous Dues &amp; Permits</u>	<u>925</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>79,772</u>	_____	_____	<u>Miscellaneous Inspections &amp; Licenses</u>	<u>520</u>	
<b>(List each licensed administrator separately.)</b>			_____	_____	_____	<u>Allocation from Management Co.</u>	<u>107</u>	
<b>B. Administrative - Other</b>				_____	_____	<u>Less: Non-Allowable Dues</u>	<u>(3,825)</u>	
<b>Description</b>			<b>Amount</b>	_____	_____	<u>Less: Public Relations Expense</u>	( _____ )	
<u>SW Management Co.-Home Office &amp; Management Fees</u>			\$ <u>37,785</u>	_____	_____	<u>Non-allowable advertising</u>	( _____ )	
<u>Ronnie Klein-Management Fees</u>			<u>120,000</u>	_____	_____	<u>Yellow page advertising</u>	( _____ )	
_____			_____	_____	_____	_____	_____	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ <u>157,785</u>	<b>TOTAL (agree to Schedule V,</b>	<b>\$ <u>399,289</u></b>	<b>TOTAL (agree to Sch. V,</b>	<b>\$ <u>4,241</u></b>	
<b>(Attach a copy of any management service agreement)</b>			_____	<b>line 22, col.8)</b>	_____	<b>line 20, col. 8)</b>	_____	
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Helper, Broom, MacDonald, Hebrank</u>	<u>Legal</u>		\$ <u>1,913</u>	<u>N/A</u>		\$ _____	<u>Out-of-State Travel</u>	\$ _____
<u>Stone, Macguire &amp; Siegel</u>	<u>Legal</u>		<u>5,702</u>	_____	_____	_____	_____	_____
<u>Ashman &amp; Stein</u>	<u>Legal</u>		<u>738</u>	_____	_____	_____	_____	_____
<u>Personnel Planners, Inc.</u>	<u>U/E Consultant</u>		<u>1,939</u>	_____	_____	_____	<u>In-State Travel</u>	_____
<u>McGladrey &amp; Pullen, LLP</u>	<u>Accounting</u>		<u>16,186</u>	_____	_____	_____	_____	_____
<u>Frost, Ruttenberg &amp; Rothblatt</u>	<u>Accounting</u>		<u>206</u>	_____	_____	_____	_____	_____
_____	_____		_____	_____	_____	_____	_____	_____
_____	_____		_____	_____	_____	_____	<u>Seminar Expense</u>	<u>1,509</u>
_____	_____		_____	_____	_____	_____	<u>Allocation from Management Co.</u>	<u>13</u>
_____	_____		_____	_____	_____	_____	_____	_____
_____	_____		_____	_____	_____	_____	<u>Entertainment Expense</u>	( _____ )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>26,684</u>	<b>TOTAL</b>		\$ _____	<b>(agree to Sch. V,</b>	_____
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>			_____	_____	_____	_____	<b>line 24, col. 8)</b>	<b>\$ <u>1,522</u></b>

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

\*\*See instructions.

Caseyville Nursing & Rehabilitation Center, Inc.

Provider # : 0039644

12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3) 26,684

Allocated from Real Estate Entity - Accounting 6,500

Allocated from Mangement Company

- Legal 3,030

- Accounting 834

Allocated from Mangement Company 3,864

Less : Non-Allowable Legal Costs (642)

Total ( Agree to Schedule V, Line 19, Column 8) 36,406

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
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19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Caseyville Nursing &amp; Rehabilitation Center

# 0039644

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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 \$5,250
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 107 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. \$ 82,350  
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. \$ 5,083 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 services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees