



Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651 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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,134	129	2,027	7,290	8
9	SNF/PED					9
10	ICF	29,656	69		29,725	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,790	198	2,027	37,015	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.42%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
 YES  NO  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 06/01/94

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date 06/01/94 NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 27 and days of care provided 2,027

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cent # 0039651 Report Period Beginning: 01/01/2008 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	225,584	15,715	3,576	244,875		244,875		244,875		1
2	Food Purchase		177,537		177,537		177,537	(4,627)	172,910		2
3	Housekeeping	166,216	48,012		214,228		214,228	120	214,348		3
4	Laundry	48,637	22,992		71,629		71,629		71,629		4
5	Heat and Other Utilities			128,550	128,550		128,550	1,174	129,724		5
6	Maintenance	80,297	34,420	12,543	127,260		127,260	2,590	129,850		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	520,734	298,676	144,669	964,079		964,079	(743)	963,336		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	1,529,533	30,185	5,754	1,565,472		1,565,472	284	1,565,756		10
10a	Therapy			300,450	300,450		300,450		300,450		10a
11	Activities	55,086	2,943		58,029		58,029		58,029		11
12	Social Services	78,561			78,561		78,561		78,561		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,663,180	33,128	309,504	2,005,812		2,005,812	284	2,006,096		16
	<b>C. General Administration</b>										
17	Administrative	69,130		304,646	373,776		373,776	(239,686)	134,090		17
18	Directors Fees										18
19	Professional Services			50,807	50,807		50,807	9,507	60,314		19
20	Dues, Fees, Subscriptions & Promotions			8,250	8,250		8,250	(3,718)	4,532		20
21	Clerical & General Office Expenses	129,443		32,933	162,376		162,376	34,200	196,576		21
22	Employee Benefits & Payroll Taxes			307,469	307,469		307,469	3,495	310,964		22
23	Inservice Training & Education										23
24	Travel and Seminar			995	995		995	13	1,008		24
25	Other Admin. Staff Transportation			4,895	4,895		4,895	1,189	6,084		25
26	Insurance-Prop.Liab.Malpractice			15,850	15,850		15,850	16,863	32,713		26
27	Other (specify):* <b>Mgmt Alloc of Benefit</b>							14,891	14,891		27
28	<b>TOTAL General Administration</b>	198,573		725,845	924,418		924,418	(163,246)	761,172		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,382,487	331,804	1,180,018	3,894,309		3,894,309	(163,705)	3,730,604		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	
	<b>D. Ownership</b>											
30	Depreciation			46,098	46,098		46,098	230,015	276,113			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,423	42,423		42,423	338,173	380,596			32
33	Real Estate Taxes							76,985	76,985			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>							31,238	31,238			36
37	<b>TOTAL Ownership</b>			808,521	808,521		808,521	(42,548)	765,973			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,758		55,758		55,758		55,758			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>			17,086	17,086		17,086	(17,086)				43
44	<b>TOTAL Special Cost Centers</b>		55,758	99,436	155,194		155,194	(17,086)	138,108			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,382,487	387,562	2,087,975	4,858,024		4,858,024	(223,339)	4,634,685			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	47,005	30		9
10	Interest and Other Investment Income	(42,353)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(243)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,900)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(857)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,737)	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	(400)	43		28
29	Other-Attach Schedule See Pg. 5A	(3,154)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (8,639)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(214,700)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (214,700)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (223,339)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing & Rehabilitation Center

ID# 0039651

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (4,254)	43	1
2	X-Rays-Part A	(3,552)	43	2
3	Uniforms Revenue	(78)	21	3
4	Association Dues	(3,825)	20	4
5	Real Estate Taxes	8,555	33	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	<b>Total</b>	(3,154)		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 Schedule 6A		See Schedule 6B		See 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	\$	Virgil Calvert Property LLC	100.00%	\$ 6,500	\$ 6,500	1
2	V	21 Office Expense		Virgil Calvert Property LLC	100.00%	261	261	2
3	V	30 Depreciation		Virgil Calvert Property LLC	100.00%	180,160	180,160	3
4	V	32 Interest Income	70	Virgil Calvert Property LLC	100.00%		(70)	4
5	V	32 Interest		Virgil Calvert Property LLC	100.00%	375,926	375,926	5
6	V	33 Real Estate Taxes		Virgil Calvert Property LLC	100.00%	64,931	64,931	6
7	V	34 Rent-Facility & Grounds	720,000	Virgil Calvert Property LLC	100.00%		(720,000)	7
8	V	36 Mortgage Insurance		Virgil Calvert Property LLC	100.00%	31,238	31,238	8
9	V	21 Miscellaneous Income	5,840	Virgil Calvert Property LLC	100.00%		(5,840)	9
10	V	26 Insurance		Virgil Calvert Property LLC	100.00%	16,301	16,301	10
11	V	32 Amortization		Virgil Calvert Property LLC	100.00%	4,670	4,670	11
12	V							12
13	V							13
14	Total		\$ 725,910			\$ 679,987	\$ * (45,923)	14

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

Virgil Calvert Nursing & Rehabilitation Center, Inc.

Provider #: 0039651

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 & 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	304,646	SW Management Co.	100.00%	64,960	(239,686)
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 & 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		\$ 304,646			\$ 136,725	\$ * (167,921)

\* 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	\$ 5,670	S & E Medical Supply Co.	100.00%	\$ 4,530	\$ (1,140)
16	V	10 Medical Supplies	2,041	S & E Medical Supply Co.	100.00%	2,325	284
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	Total		\$ 7,711			\$ 6,855	\$ * (856)

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cen # 0039651 Report Period Beginning: 01/01/2008 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	5	12.50	Salary	\$ 23,200	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.50	See Schedule 7B	5	10.00	Salary & Fees	18,560	L17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	5	12.50	Salary	23,200	L21,C7	3
4											4
5											5
6											6
7			Note: All individuals work in excess of 40 hours per week.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,960		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center # 0039651 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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

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

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

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	Maintenace	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 & 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	17	Administrative	Average Hrs Worked	40	11	371,200	371,200	5	46,400	16
17	17	Administrative	Average Hrs Worked	50	6	185,600	185,600	5	18,560	17
18									18	
19	30	Depreciation	Direct Cost					2,850	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 136,725	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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 Ave.  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number (847) 982-9300  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 4,530	1
2	10	Medical Supplies	Direct Cost					2,325	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				\$	\$		\$ 6,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Heartland Bank		X	Mortgage	\$23,524.00	11/27/01	\$ 6,359,200	\$ 5,943,389	12/1/36	0.0635	\$ 375,926	1								
2												2								
3							Amortization of Mortgage Costs				4,670	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	N/P Stockholder	X		Working Capital				550,000	Demand	Variable	24,597	6								
7	Intercompany Loan	X		Working Capital				425,390	Demand	0.0600	17,826	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$23,524.00		\$ 6,359,200	\$ 6,918,779			\$ 423,019	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11							Interest Income offset				(989)	11								
12							Related Party Interest net of Interest Income				(41,364)	12								
13							Real Estate Entity Interest Income Offset				(70)	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (42,423)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 6,359,200	\$ 6,918,779			\$ 380,596	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,238 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>208,000</b>	1
	Vacant Land 2005		<b>8,555</b>	
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>134,431</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(65,014)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>138,500</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
	Allocation to Management Compnay		<b>3,499</b>	
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>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>76,985</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<b>162,337</b>	8	
	2004	<b>182,632</b>	9	
	2005	<b>182,236</b>	10	
	2006	<b>197,469</b>	11	
	2007	<b>134,431</b>	12	
<b>2008 real estate tax accrual- 134,431 * 0.97 = 138,464.</b>				
<b>Use : 138,500</b>				
	<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 Virgil Calvert Nursing & Rehabilitation Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039651

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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>02-21.0-209-023</u>	<u>Long-term care property</u>	\$ <u>134,431.44</u>	\$ <u>134,431.44</u>
2. <u>02-21.0-209-022</u>	<u>Long-term care property</u>	\$ <u>8,555.22</u>	\$ <u>8,555.22</u>
3. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>43,500.34</u>	\$ <u>3,499.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>186,487.00</u>	\$ <u>146,485.66</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

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>2001</u>	<u>\$ 400,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 400,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

# 0039651

Report Period Beginning:

01/01/2008 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		\$ 4,801,298	\$	15-40	\$ 132,029	\$ 132,029	\$ 935,205	4
5										5
6	Mgmt. Co.	1995		36,141		39	1,033	1,033	13,068	6
7										7
8										8
	Improvement Type**									
9	Various		1994	30,237	725	20	1,512	787	22,354	9
10	Various		1995	25,180	459	20	1,259	800	17,454	10
11	Various		1996	5,688	243	20	284	41	3,600	11
12	Various		1997	4,115	106	20	206	100	2,402	12
13	Various		1998	4,092		20	205	205	2,421	13
14	Various		1999	27,640		20	1,430	1,430	13,367	14
15	Concrete Work		2000	3,181	82	20	159	77	1,352	15
16	Concrete Work		2000	5,030	129	20	252	123	2,139	16
17	Concrete Work		2000	5,195	133	20	260	127	2,209	17
18	Exhaust Fan		2000	3,820		20	191	191	1,878	18
19	Water Heater		2000	5,300		20	265	265	2,562	19
20	Carpeting		2000	5,400		20	270	270	2,520	20
21	Mechanical Room Volv		2000	1,315		20	66	66	527	21
22	Check Valve		2000	877		20	44	44	351	22
23	Plumbing		2000	1,024		20	51	51	409	23
24	100 Gal. Waterheater		2001	4,642		20	232	232	2,927	24
25	Steamer		2001	2,545		20	127	127	1,604	25
26	Concentrator		2001	2,703		7	129	129	2,703	26
27	Air Conditioner		2001	1,895		20	95	95	1,195	27
28	Fire Protection		2001	6,752		20	338	338	4,258	28
29	Air Conditioner		2001	8,313		20	416	416	5,243	29
30	Sprinkler Heads		2001	3,273		20	164	164	2,065	30
31	Blinds		2001	1,212		20	61	61	765	31
32	Sprinkler System Rep		2001	1,827		20	91	91	669	32
33	Heating Systems Repr		2001	1,269		20	63	63	449	33
34	Dining Room Wall		2002	11,663	209	10	1,166	957	7,775	34
35	Dining Room Wall		2002	8,020	144	10	802	658	5,347	35
36	Air Conditioners		2002	1,659		7	237		1,560	36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

# 0039651

Report Period Beginning:

01/01/2008 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	Air Conditioners	2002	\$ 2,185	\$	7	\$ 312	\$ 312	\$ 2,055	37
38	Front Door	2003	9,860	253	20	493	240	2,958	38
39	Roof	2003	72,800	1,867	20	3,640	1,773	21,233	39
40	Gutters And Soffits	2003	24,221	621	20	1,211	590	6,862	40
41	Nursing Station	2003	2,901		20	145	145	834	41
42	Nursing Station	2003	13,285		20	664	664	3,819	42
43	Nursing Station	2003	12,188		20	609	609	3,301	43
44	Fire Sprinkler System	2003	2,075		20	104	104	580	44
45	Fire Suppression System	2003	2,030		20	102	102	559	45
46	100 Gl. Water Heater	2003	3,085		20	154	154	925	46
47	Resident Room Casework/counters	2003	7,259		20	363	363	2,057	47
48	Pipe/Dry system	2004	2,472	90	20	124	34	557	48
49	Air Compressor	2004	2,766	66	20	138	72	622	49
50	Condensing unit and evaporator	2004	2,230	90	20	112	22	502	50
51	Concrete removal/new pipe	2004	6,111	248	20	306	58	1,375	51
52	A/C unit in Laundry System	2004	3,329	121	20	166	45	749	52
53	Sprinkler System	2004	2,056	75	20	103	28	463	53
54	Duct Heater	2005	1,381	50	20	69	19	242	54
55	Freezer Door	2005	2,100	242	20	105	(137)	368	55
56	Wallpaper	2005	14,510	1,672	20	726	(947)	2,540	56
57	Water Heaters	2005	5,724	208	20	286	78	1,002	57
58	Security System	2005	25,534	929	20	1,277	348	4,469	58
59	Compressor	2005	1,090	40	20	55	15	191	59
60	Water Heater	2005	1,490	54	20	75	21	261	60
61	Painting & Wallcovering	2005	38,792	4,469	20	1,940	(2,529)	6,789	61
62	Carpet	2005	3,164	516	20	158	(358)	554	62
63	Vinyl floor	2005	6,327	182	20	316	134	1,107	63
64	Doors	2005	1,925	70	20	96	26	337	64
65	Asphalt-parking lot	2005	8,500	654	20	425	(229)	1,488	65
66	Custom built duct heater	2005	1,704	62	20	85	23	298	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,304,400	\$ 14,809		\$ 157,792	\$ 142,746	\$ 1,129,471	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 Virgil Calvert Nursing &amp; Rehabilitation Center

# 0039651

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>		\$ 5,304,400	\$ 14,809		\$ 157,792	\$ 142,983	\$ 1,129,471	1
2	Kitchen Floor	2006	9,998	364	20	500	136	1,250	2
3	A/C Units	2006	2,146		20	107	107	268	3
4	A/C Units	2006	2,576		20	129	129	322	4
5	2 Ton A/C Unit	2006	1,208	44	20	60	16	151	5
6	Sprinkler System-Replace Pipes	2006	8,357	304	20	418	114	1,045	6
7	Remodel Shower Hall - 500	2007	21,570	784	20	1,079	295	1,618	7
8	Remodel Shower Hall - 400	2007	21,570	784	20	1,079	295	1,618	8
9	Remodel Shower Hall - 200	2007	21,570	784	20	1,079	295	718	9
10	Handrail	2007	3,425		20	171	171	257	10
11	Freezer Compressor	2007	2,202	80	20	110	30	165	11
12	5 Ton Air Handler	2007	2,795	102	20	140	38	210	12
13	2 Ton Air Handler & 3 Ton Condensing Unit	2007	5,241	191	20	262	71	393	13
14	Asphalt Parking Lot	2008	28,482	14,953	20	712	(14,241)	712	14
15	Asphalt Path	2008	9,820	5,156	20	246	(4,910)	246	15
16	Sprinkler System Renovation	2008	16,034	316	20	399	83	399	16
17									17
18									18
19	SW Management Allocation - leasehold improvements	1995	3,856		20	193	193	2,905	19
20	SW Management Allocation - leasehold improvements	1996	673		20	34	34	423	20
21	SW Management Allocation - leasehold improvements	1997	970		20	49	49	677	21
22	SW Management Allocation - leasehold improvements	1998	668		20	33	33	359	22
23	SW Management Allocation - leasehold improvements	1999	1,854		20	93	93	842	23
24	SW Management Allocation - leasehold improvements	2005	3,835		20	192	192	671	24
25	SW Management Allocation - leasehold improvements	2007	2,171		20	109	109	163	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,475,421	\$ 38,671		\$ 164,987	\$ 126,316	\$ 1,144,883	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	\$ 866,421	\$ 3,091	\$ 109,651	\$ 106,560	10	\$ 845,050	71
72	Current Year Purchases	7,225	4,336	361	(3,975)	10	361	72
73	Fully Depreciated Assets	105,471					105,471	73
74	Allocation from Management Co.	11,410		146	146	10	8,364	74
75	TOTALS	\$ 990,527	\$ 7,427	\$ 110,158	\$ 102,731		\$ 959,246	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)	\$ 6,870,788	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,098	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 276,113	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 230,015	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,108,485	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	SW Management Allocation			1,041	18
19					19
20					20
21	TOTAL		\$	\$ 1,041	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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	\$	2,568	\$ 143,811	\$	2,568	\$ 143,811	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		529	31,758		529	31,758	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,336	121,459		2,336	121,459	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				55,758		55,758	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>			\$	5,433	\$ 297,028	\$ 55,758	5,433	\$ 352,786	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651

Report Period Beginning: 01/01/2008

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
2	Cash-Patient Deposits	13,724	13,724	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000 )	930,145	1,289,823	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,791	9,583	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch. 17A	16,888	144,206	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 965,548	\$ 1,457,336	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		4,549,525	14
15	Leasehold Improvements, at Historical Cost	475,358	925,896	15
16	Equipment, at Historical Cost	335,991	995,367	16
17	Accumulated Depreciation (book methods)	(476,960)	(2,108,485)	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		130,362	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 334,389	\$ 4,892,665	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,299,937	\$ 6,350,001	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 182,697	\$ 131,447	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,156	17,156	28
29	Short-Term Notes Payable	975,390	975,390	29
30	Accrued Salaries Payable	52,377	52,377	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,075	8,075	31
32	Accrued Real Estate Taxes(Sch.IX-B)		138,500	32
33	Accrued Interest Payable		43,299	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Sch. 17A	717,693	717,693	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,953,388	\$ 2,083,937	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,943,389	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>	\$	\$ 5,943,389	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,953,388	\$ 8,027,326	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (653,451)	\$ (1,677,325)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,299,937	\$ 6,350,001	48

Virgil Calvert Nursing & Rehabilitation Center, Inc.  
Provider #: 0039651  
12/31/08

Schedule 17A

**XV. BALANCE SHEET -**

<b>Other Current Assets (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Replacement Reserve	-	41,628
Due from state	2,031	2,031
Employee Payroll Advance	464	464
Other - Escrow	-	85,690
Due From/To Vir Vacant Land	14,393	14,393
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>16,888</b>	<b>144,206</b>

<b>Other Long-Term Assets (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Capitalized Costs	-	163,434
Accumulated Amortization	-	(33,072)
<b>Total Line 22 - Other Long-Term Assets (specify)</b>	<b>-</b>	<b>130,362</b>

<b>Other Current Liabilities (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Reimbursement Due	250,599	250,599
Insurance Premiums Payable	8,758	8,758
Acc. Retirement (From P/R)	-	-
Accrued Expenses	78,286	78,286
Due to Public Aid	-	-
Due/from Virgil Property LLC	380,050	380,050
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b>717,693</b>	<b>717,693</b>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(315,209)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Period Adjustment</b>	<b>(3,780)</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>(318,989)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(334,462)</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>(334,462)</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>(653,451)</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	\$ 4,189,952	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,189,952	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	333,896	6
7	Oxygen	(1,353)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 332,543	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	989	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 989	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Uniforms</u>	78	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 78	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,523,562	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	964,079	31
32	Health Care	2,005,812	32
33	General Administration	924,418	33
	<b>B. Capital Expense</b>		
34	Ownership	808,521	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	72,844	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>	\$ 4,858,024	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(334,462)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (334,462)	43

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

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

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

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651

Report Period Beginning: 01/01/2008

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	453	461	\$ 14,611	\$ 31.69	1
2	Assistant Director of Nursing	2,767	3,004	76,477	25.46	2
3	Registered Nurses	3,120	3,211	71,260	22.19	3
4	Licensed Practical Nurses	26,015	26,996	525,722	19.47	4
5	CNAs & Orderlies	72,101	76,571	761,530	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,691	6,149	79,933	13.00	8
9	Activity Director					9
10	Activity Assistants	5,583	5,890	55,086	9.35	10
11	Social Service Workers	5,400	5,776	78,561	13.60	11
12	Dietician					12
13	Food Service Supervisor	1,902	2,014	30,012	14.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,132	20,904	195,572	9.36	15
16	Dishwashers					16
17	Maintenance Workers	4,063	4,315	80,297	18.61	17
18	Housekeepers	17,793	18,999	166,216	8.75	18
19	Laundry	5,949	6,238	48,637	7.80	19
20	Administrator	1,976	2,160	69,130	32.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,451	6,740	129,443	19.21	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)	178,396	189,428	\$ 2,382,487 *	\$ 12.58	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	76	\$ 3,576	L1, C3	35
36	Medical Director	Monthly	3,300	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	94	5,754	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	49	3,422	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)	219	\$ 16,052		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>Kathleen Crawford</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 69,130</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 56,524</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>33,850</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>182,261</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>31,036</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>	<u>3,495</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/Disability</u>	<u>3,723</u>	<u>Miscellaneous Inspections &amp; Licenses</u>	<u>1,010</u>	
				<u>Holiday Expense</u>	<u>75</u>	<u>Allocation from Management Co.</u>	<u>107</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 69,130</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>\$ 310,964</b>	
<b>(List each licensed administrator separately.)</b>				<b>(agree to Sch. V, line 20, col. 8)</b>			<b>\$ 4,532</b>	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>SW Management-Home Office &amp; Management Fees</u>			<u>\$ 184,646</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>Ronnie Klein-Management Fees</u>			<u>120,000</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 304,646</b>				<u>In-State Travel</u>	
<b>(Attach a copy of any management service agreement)</b>								
<b>C. Professional Services</b>				<b>TOTAL</b>				
Vendor/Payee	Type		Amount				<u>Seminar Expense</u>	<u>995</u>
<u>Helper, Broom, MacDonald</u>	<u>Legal</u>		<u>\$ 25,860</u>				<u>Allocation from Management Co.</u>	<u>13</u>
<u>Ashman &amp; Stein</u>	<u>Legal</u>		<u>5,848</u>				<u>Entertainment Expense</u>	<u>(</u>
<u>Stone, McGuire &amp; Siegel</u>	<u>Legal</u>		<u>855</u>				(agree to Sch. V,	
<u>McGladrey &amp; Pullen, LLP</u>	<u>Accounting</u>		<u>16,186</u>				line 24, col. 8)	
<u>Peronnel Planners</u>	<u>Unemployment Consulting</u>		<u>1,852</u>				<b>TOTAL</b>	<b>\$ 1,008</b>
<u>Frost, Ruttenberg &amp; Rothblatt</u>	<u>Accounting</u>		<u>206</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 50,807</b>					
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

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

\*\*See instructions.

Virgil Calvert Nursing & Rehabilitation Center, Inc.

Provider # 0039651

12/31/2008

Schedule 21A

XIX. Support Schedule

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	50,807
Non Allowable Legal	(857)
Allocated from Virgil Calvert Property LLC:	6,500
Allocated from SW Management:	3,864
Total (agree to Schedule V, line 19, column 8)	<u>60,314</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4	N/A																			
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center# 0039651Report Period Beginning: 01/01/2008Ending: 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. IL 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. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,350  
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.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,495 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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

**SEE ACCOUNTANTS' COMPILATION REPORT**