FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0039644

Facility Name: Caseyville Nursing & Rehabilitation Center

Address: 601 West Lincoln Avenue (Number) Caseyville (City) 62232 (Zip Code)

County: St. Clair

Telephone Number: (618) 345-3072 **Fax #** (847) 345-3170

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,332	438	3,844	5,614	8
9	SNF/PED					9
10	ICF	33,731	6,015		39,746	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,063	6,453	3,844	45,360	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.85%

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 [X] 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 [X]

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 [X] Date 06/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3,844

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	250,604	18,890	4,855	274,349		274,349		274,349			1
2	Food Purchase		276,187		276,187		276,187	(7,433)	268,754			2
3	Housekeeping	122,832	59,183		182,015		182,015	83	182,098			3
4	Laundry	140,446	7,027		147,473		147,473		147,473			4
5	Heat and Other Utilities			175,712	175,712		175,712	1,254	176,966			5
6	Maintenance	94,542	99,911	10,384	204,837		204,837	535	205,372			6
7	Other (specify):*											7
8	TOTAL General Services	608,424	461,198	190,951	1,260,573		1,260,573	(5,561)	1,255,012			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,820,038	58,850	945	1,879,833		1,879,833	1,003	1,880,836			10
10a	Therapy			730,386	730,386		730,386		730,386			10a
11	Activities	77,347	9,165		86,512		86,512		86,512			11
12	Social Services	55,401			55,401		55,401		55,401			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,952,786	68,015	737,331	2,758,132		2,758,132	1,003	2,759,135			16
	C. General Administration											
17	Administrative	74,429		188,400	262,829		262,829	(140,557)	122,272			17
18	Directors Fees											18
19	Professional Services			70,518	70,518		70,518	9,491	80,009			19
20	Dues, Fees, Subscriptions & Promotions			20,905	20,905		20,905	(3,124)	17,781			20
21	Clerical & General Office Expenses	368,548		38,655	407,203		407,203	44,252	451,455			21
22	Employee Benefits & Payroll Taxes			419,481	419,481		419,481	5,119	424,600			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,604	2,604		2,604	44	2,648			24
25	Other Admin. Staff Transportation			29,229	29,229		29,229	972	30,201			25
26	Insurance-Prop.Liab.Malpractice			11,860	11,860		11,860	6,438	18,298			26
27	Other (specify):* Mgmt Alloc of Benefit							12,944	12,944			27
28	TOTAL General Administration	442,977		781,652	1,224,629		1,224,629	(64,421)	1,160,208			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,004,187	529,213	1,709,934	5,243,334		5,243,334	(68,979)	5,174,355			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: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			40,204	40,204		40,204	169,946	210,150			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							384,293	384,293			32
33	Real Estate Taxes							80,514	80,514			33
34	Rent-Facility & Grounds			626,000	626,000		626,000	(626,000)				34
35	Rent-Equipment & Vehicles							918	918			35
36	Other (specify):* Mortgage Insurance							29,872	29,872			36
37	**TOTAL Ownership**			666,204	666,204		666,204	39,543	705,747			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,893		123,893		123,893		123,893			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Non-Allowable Cos			68,188	68,188		68,188	(68,188)				43
44	**TOTAL Special Cost Centers**		123,893	150,313	274,206		274,206	(68,188)	206,018			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,004,187	653,106	2,526,451	6,183,744		6,183,744	(97,624)	6,086,120			45

***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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	17,287	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(473)	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	(708)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,524)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,000)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(19,961)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,379)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(43,245)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (43,245)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (97,624)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Caseyville Nursing & Rehabilitation Center

ID# 0039644

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (11,534)	43	1
2	X Ray Expense Med A	(4,949)	43	2
3	Lobbying Expense	(3,478)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(19,961)		49

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Caseyville Property LLC	100.00%	$ 7,700	$ 7,700	1
2	V	26	Insurance		Caseyville Property LLC	100.00%	5,985	5,985	2
3	V	30	Depreciation		Caseyville Property LLC	100.00%	150,158	150,158	3
4	V	32	Interest		Caseyville Property LLC	100.00%	379,544	379,544	4
5	V	32	Interest Income		Caseyville Property LLC	100.00%	(92)	(92)	5
6	V	33	Real Estate Taxes		Caseyville Property LLC	100.00%	77,820	77,820	6
7	V	34	Rent	626,000	Caseyville Property LLC	100.00%		(626,000)	7
8	V	36	Mortgage Insurance		Caseyville Property LLC	100.00%	29,872	29,872	8
9	V	32	Amortization		Caseyville Property LLC	100.00%	4,784	4,784	9
10	V	20	Dues Fees Subscriptions		Caseyville Property LLC	100.00%	266	266	10
11	V								11
12	V								12
13	V								13
14	Total			$ 626,000			$ 656,037	$ * 30,037	14

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

Caseyville Nursing & Rehabilitation Center, Inc.
Provider #: 0039644
1/1/2010 to 12/31/2010

VII Related Parties - Page 6 Schedule 6A

Share Numbe	Shareholder Name	Beginning Shares	Ownership Percentage
1	Abraham J Stern	70	4.67
2	Albert Milstein	395	26.33
3	Sheldon Wolfe	355	23.67
4	Ronnie Klein as Trustee	75	5
5	Maurice Aaron	70.1	4.67
6	Michael Klein Revocable Trust	30	2
7	Wanda Bowling	10	0.67
8	Michael A Klein as Custodian	100	6.67
9	Michael A Klein as Trustee	100	6.67
10	Kenneth Klein	75	5
11	Susan Stern	70	4.67
12	Jonathan B Stern 2001 Trust	23.33	1.56
13	Todd A. Stern 2001 Trust	23.33	1.56
14	Evan M. Stern	23.33	1.56
16	Ora Aaron	70	4.67
17	Moshe Herman	10	0.67

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehabilitation Center, Inc.
Provider #: 0039644
1/1/2010 to 12/31/2010

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:	
Rosewood Health and Rehab	Independence, MO
Beauvais Manor Healthcare and Rehab	St. Louis, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Management Co.	100.00%	$ 144	$ 144	15
16	V	3	Housekeeping		SW Management Co.	100.00%	83	83	16
17	V	5	Heat and Other Utilties		SW Management Co.	100.00%	1,254	1,254	17
18	V	6	Maintenance		SW Management Co.	100.00%	535	535	18
19	V	17	Administrative	188,400	SW Management Co.	100.00%	47,843	(140,557)	19
20	V	19	Professional Services		SW Management Co.	100.00%	1,791	1,791	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	88	88	21
22	V	21	Clerical & General Office Expense		SW Management Co.	100.00%	44,252	44,252	22
23	V	24	Travel and Seminar		SW Management Co.	100.00%	44	44	23
24	V	25	Other Admin. Staff Transport		SW Management Co.	100.00%	972	972	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	453	453	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,944	12,944	26
27	V	30	Depreciation		SW Management Co.	100.00%	2,501	2,501	27
28	V	32	Interest		SW Management Co.	100.00%	57	57	28
29	V	33	Real Estate Taxes		SW Management Co.	100.00%	2,694	2,694	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.	100.00%	918	918	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 188,400			$ 116,573	$ * (71,827)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 11,385	S & E Medical Supply Co.	100.00%	$ 8,927	$ (2,458)	15
16	V	3	Housekeeping	2,132	S & E Medical Supply Co.	100.00%	2,132		16
17	V	10	Medical Supplies	2,515	S & E Medical Supply Co.	100.00%	3,518	1,003	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 16,032			$ 14,577	$ * (1,455)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	6	14.29	Salary	$ 14,072	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	5	10.00	Salary&Fees	19,700	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	6	14.29	Salary	14,071	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	$ 47,843		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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	742,930	12	$ 1,959	$	54,750	$ 144	1
2	3	Housekeeping	Bed Days Available	742,930	12	1,125		54,750	83	2
3	5	Heat and Other Utilities	Bed Days Available	742,930	12	17,016		54,750	1,254	3
4	6	Maintenance	Bed Days Available	742,930	12	7,264		54,750	535	4
5	19	Professional Services	Bed Days Available	742,930	12	24,293		54,750	1,791	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	742,930	12	1,198		54,750	88	6
7	21	Clerical & General Office Exp	Bed Days Available	742,930	12	600,468	509,094	54,750	44,252	7
8	24	Travel and Seminar	Bed Days Available	742,930	12	594		54,750	44	8
9	25	Other Admin. Staff Transport	Bed Days Available	742,930	12	13,194		54,750	972	9
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	742,930	12	6,148		54,750	453	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	742,930	12	175,644		54,750	12,944	11
12	32	Interest	Bed Days Available	742,930	12	778		54,750	57	12
13	33	Real Estate Taxes	Bed Days Available	742,930	12	36,555		54,750	2,694	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	742,930	12	12,454		54,750	918	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	84	12	394,000	394,000	6	28,143	17
18	17	Administrative	Avg. Hours Worked	50	6	197,000	197,000	5	19,700	18
19										19
20	30	Depreciation	Direct Cost	33,940					2,501	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,489,690	$ 1,100,094		$ 116,573	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost	8,927		$	$		$ 8,927	1
2	3	Housekeeping	Direct Cost	2,132					2,132	2
3	10	Medical Supplies	Direct Cost	3,518					3,518	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					$	$		$ 14,577	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Heartland Bank		X	Mortgage	$38,896.00	11/27/01	$ 6,814,000	$ 5,934,021	12/1/36	0.0635	$ 379,544	1
2												2
3								Amortization of Mortgage Costs			4,784	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$38,896.00		$ 6,814,000	$ 5,934,021			$ 384,328	9
	B. Non-Facility Related*											
10												10
11							Allocation from Management Co.				57	11
12							Interest income offset from Real Estate Entity				(92)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (35)	14
15	TOTALS (line 9+line14)						$ 6,814,000	$ 5,934,021			$ 384,293	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 29,872 **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.)**

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 73,500	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.)	2009	$ 74,520	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,020	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,800	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	Mgmt Co.	$ 365	5
	Allocated from Management Co.	2,329	
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. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 80,514	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	88,605	8
	2006	94,408	9
	2007	96,110	10
	2008	71,359	11
	2009	74,520	12

2010 Tax Accrual = $74,520 X 1.03 = 76,756. Will use $76,800.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-07.0-300-005	Long Term Care Property	$ 74,520.26	$ 74,520.26
2.	10-28-412-049-0000	SW Management Allocation	$ 32,484.00	$ 2,329.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 107,004.26	$ 76,849.26

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2001	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2001		$ 5,265,179	$	39	$ 146,726	$ 146,726	$ 1,326,106	4
5											5
6											6
7	Management Allocation		1995		31,898		39	911	911	14,267	7
8											8
	Improvement Type**										
9	Various			1994	22,304	58	20	1,115	1,057	18,107	9
10	Various			1995	52,604	107	20	2,630	2,523	40,811	10
11	Various			1996	2,492		20	125	125	1,934	11
12	Various			1997	11,349	43	20	567	524	7,663	12
13	Various			1998	14,511	227	20	726	499	9,924	13
14	Various			1999	83,394	613	20	4,170	3,557	48,019	14
15	Parking Lot			2000	2,830	167	20	142	(26)	1,464	15
16	Sprinkler System			2000	3,385	87	20	169	82	1,805	16
17	Sprinkler System			2000	5,820	149	20	291	142	3,128	17
18	A/C Repairs			2000	1,018		10	41	41	1,018	18
19	Ac Repairs			2000	1,102		20	55	55	583	19
20	Draperies			2000	1,052		20	53	53	540	20
21	Carpeting			2000	1,578		20	79	79	843	21
22	Air Handler			2000	1,786		20	89	89	938	22
23	Air Conditioner			2000	1,963		7			1,324	23
24	Air Handler			2000	1,241		20	62	62	651	24
25	Air Conditioner			2000	1,029		20	51	51	547	25
26	Compressor			2000	1,800		20	90	90	990	26
27	Booster Heater			2000	1,675		20	84	84	923	27
28	Air Conditioner			2000	5,821		20	291	291	3,007	28
29	Air Conditioner			2000	17,320		20	866	866	9,165	29
30	Air Conditioner			2001	3,630		20	182	182	1,756	30
31	Air Conditioner			2001	3,630		20	182	182	1,756	31
32	Air Conditioner			2001	3,111		20	156	156	1,505	32
33	Blinds			2001	1,212		20	61	61	597	33
34	Sprinkler Repair			2001	1,609		20	80	80	790	34
35	Sprinkler Heads			2001	2,145		20	107	107	1,036	35
36	Pipes Repair			2001	1,903		20	95	95	864	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dining Room Wall	2002	$ 10,650	$ 191	10	$ 1,065	$ 874	$ 9,230	37
38	Water Heater	2002	4,900		12	408	408	3,641	38
39	Circuit Breaker	2002	1,390		10	139	139	1,228	39
40	Air Conditioners	2002	2,890		7			2,855	40
41	Air Conditioners	2002	4,284		7			4,284	41
42	Water Heater	2002	2,249		12	187	187	1,530	42
43	Doors	2003	9,995	256	20	500	244	3,999	43
44	Dry Value System	2003	5,623	144	20	281	137	2,132	44
45	Landscaping	2003	8,800	520	20	440	(80)	3,227	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	12,396	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	679	47
48	P.A. Amplifier	2003	713		20	36	36	286	48
49	Security Systems	2004	23,268	846	20	1,163	317	7,562	49
50	16 Transmitters	2004	1,517	55	20	76	21	493	50
51	Nurses Stations	2004	35,000	1,273	20	1,750	477	11,375	51
52	Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	15,188	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	23,633	53
54	Air Conditioners	2005	20,666	1,190	7	2,067	877	20,666	54
55	Freezer Door	2005	2,100		20	105	105	578	55
56	Wallpaper	2005	16,140		5	1,614	1,614	16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	1,525	57
58	Painting and Wallcovering	2005	38,520		5	3,852	3,852	38,520	58
59	Air Condensors	2005	6,270	228	20	314	86	1,725	59
60	Vinyl Flooring	2005	5,009	182	5	501	319	5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	436	15	467	31	2,567	61
62	Metal Doors	2005	1,926	70	20	96	26	529	62
63	Kitchen Floor	2006	10,300	375	20	515	140	2,318	63
64	Sprinkler System	2006	9,529	346	20	476	130	2,144	64
65	Door Monitors & Paging System	2006	811	29	20	41	12	183	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	941	66
67	6 A/C Units	2006	2,576	296	20	129	(167)	580	67
68	6 A/C Units	2006	2,576	297	20	129	(168)	580	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	1,062	69
70	TOTAL (lines 4 thru 69)		$ 5,968,900	$ 13,535		$ 185,735	$ 172,200	$ 1,700,860	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,968,900	$ 13,535		$ 185,735	$ 172,200	$ 1,700,860	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	833	2
3	Duct Heater	2006	1,349	49	20	67	18	303	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	2,073	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,105	20	2,895	790	10,133	5
6	4 Hot Water Heaters	2007	13,462	490	20	673	183	2,356	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	6,904	7
8	Repair Sprinkler System	2007	3,957	144	20	198	54	693	8
9	Oak flooring	2008	15,571	566	20	779	213	1,947	9
10	Fire alarm system	2008	8,858	322	20	443	121	1,107	10
11	Street and parking lot paving	2008	43,360	1,854	20	2,168	314	5,420	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	590	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	4,938	13
14	Replace pipe and fitting	2009	4,232	154	20	212	58	318	14
15	Air Handling Equipment	2010	22,154	437	20	554	117	554	15
16									16
17									17
18									18
19									19
20									20
21									21
22	Allocation from SW management - leasehold improvements	1995	3,570		20	178	178	3,037	22
23	Allocation from SW management - leasehold improvements	1996	594		20	30	30	433	23
24	Allocation from SW management - leasehold improvements	1997	689		20	34	34	550	24
25	Allocation from SW management - leasehold improvements	1998	589		20	29	29	376	25
26	Allocation from SW management - leasehold improvements	1999	1,636		20	82	82	907	26
27	Allocation from SW management - leasehold improvements	2005	3,384		20	169	169	931	27
28	Allocation from SW management - leasehold improvements	2007	1,916		20	96	96	335	28
29	Allocation from SW management - leasehold improvements	2009	4,000		20	200	200	300	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,252,703	$ 23,168		$ 199,371	$ 176,203	$ 1,745,896	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 928,300	$ 1,085	$ 9,211	$ 8,126	10	$ 844,471	71
72	Current Year Purchases	15,951	15,951	797	(15,154)	10	797	72
73	Fully Depreciated Assets	150,147					150,147	73
74	Allocated from Management Co.	10,072		204	204	10	7,790	74
75	TOTALS	$ 1,104,470	$ 17,036	$ 10,212	$ (6,824)		$ 1,003,205	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	Allocated from Mgmt Co.	Infiniti	2010	$ 5,667	$	$ 567	$ 567	5	$ 567	76
77										77
78										78
79										79
80	TOTALS			$ 5,667	$	$ 567	$ 567		$ 567	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)	$ 7,712,840	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,204	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,150	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 169,946	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,749,668	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.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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	Allocated from Management Co.		$	$ 918	17
18					18
19					19
20					20
21	TOTAL		$	$ 918	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	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	$	4,121	$ 296,705	$	4,121	$ 296,705	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3,061	146,932		3,061	146,932	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,381	280,378		4,381	280,378	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				123,893		123,893	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	TOTAL			$	11,563	$ 724,015	$ 123,893	11,563	$ 847,908	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

STATE OF ILLINOIS

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 333,419	$ 467,785	1
2	Cash-Patient Deposits	25,192	25,192	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,040,894	1,040,894	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,869	34,040	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	954,742	1,093,249	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,357,116	$ 2,661,160	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,297,077	14
15	Leasehold Improvements, at Historical Cost	688,175	955,626	15
16	Equipment, at Historical Cost	455,589	1,110,137	16
17	Accumulated Depreciation (book methods)	(687,709)	(2,749,668)	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 (spe See Schedule 17A		123,988	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 456,055	$ 5,087,160	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,813,171	$ 7,748,320	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 71,981	$ 78,881	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,329	27,329	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,395	81,395	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,358	15,358	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,800	32
33	Accrued Interest Payable		31,401	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	215,256	215,256	36
37	See Schedule 17A	216,936	91,663	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 628,255	$ 618,083	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,934,021	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,934,021	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 628,255	$ 6,552,104	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,184,916	$ 1,196,216	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,813,171	$ 7,748,320	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Caseyville Nursing & Rehabilitation Center, Inc. **Sch 17A**
Provider #: 0039644
12/31/2010

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
RE Replacement Reserve	-	82,802
RE Escrow-Real Estate Tax	-	55,705
Due from State - Interest	22,398	22,398
Reimbursement Due	92,553	92,553
Short Term Loan Exchange	839,791	839,791
Total Line 9-Other Current Assets (Specify)	954,742	1,093,249

Other Long-Term Assets (Specify)		
Capitalized Costs	-	167,434
Accululated Amortization	-	(43,446)
Total Line 22-Other Long-Term Assets (specify)	-	123,988

Other Current Liabilities (Specify)		
Insurance Premiums Payable	736	736
Acc. Retirement (From P/R)	(150)	(150)
Accrued Expenses	214,670	214,670
Total Line 36-Other Current Liabilities (Specify)	215,256	215,256
Due from State	91,663	91,663
Due/From Caseyville Prop. LLC	125,273	-
Total Line 37-Other Current Liabilities (Specify)	216,936	91,663

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,944,687	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,944,687	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	840,227	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	2	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 240,229	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,184,916	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,202,800	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,202,800	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	760,390	6
7	Oxygen	21,002	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 781,392	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	25	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 25	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,307	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,307	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Medicaid Income Adjustment	16,447	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,447	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,023,971	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,260,573	31
32	Health Care	2,758,132	32
33	General Administration	1,224,629	33
	B. Capital Expense		
34	Ownership	666,204	34
	C. Ancillary Expense		
35	Special Cost Centers	192,081	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,183,744	40
41	**Income before Income Taxes (line 30 minus line 40)****	840,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 840,227	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: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,037	2,114	$ 68,089	$ 32.21	1
2	Assistant Director of Nursing	1,952	2,080	59,148	28.44	2
3	Registered Nurses	2,417	2,533	65,487	25.85	3
4	Licensed Practical Nurses	26,967	28,771	614,210	21.35	4
5	CNAs & Orderlies	84,481	89,336	889,256	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,869	9,945	123,848	12.45	8
9	Activity Director					9
10	Activity Assistants	5,509	6,040	77,347	12.81	10
11	Social Service Workers	3,464	3,750	55,401	14.77	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,135	40,502	18.97	13
14	Head Cook	8,586	9,539	107,412	11.26	14
15	Cook Helpers/Assistants	11,000	11,703	102,690	8.77	15
16	Dishwashers					16
17	Maintenance Workers	5,674	6,327	94,542	14.94	17
18	Housekeepers	11,846	12,765	122,832	9.62	18
19	Laundry	15,377	16,707	140,446	8.41	19
20	Administrator	1,808	1,912	74,429	38.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,717	15,185	368,548	24.27	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)	205,608	220,842	$ 3,004,187 *	$ 13.60	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 4,855	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	945	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	6,371	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)		$ 18,171		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Geralyn Isenberg	Administrator	0	$ 74,429
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,429

B. Administrative - Other

Description	Amount
SW Management Co.-Home Office	$ 68,400
Management Fees	120,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 188,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hepler Broom LLC	Legal	$ 27,776
Stone McGuire & Siegel	Legal	672
Sherrill Associates	Legal	2,550
Stephen Sher	Legal	11,763
Polsinelli Shughart	Legal	194
	Legal	1,042
McGladrey & Pullen LLP	Accounting	20,668
Honkamp & Krueger Co.	Accounting	4,663
Personnel Planners, Inc.	U/E Consultant	1,190
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 70,518

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,451
Unemployment Compensation Insurance	70,589
FICA Taxes	229,821
Employee Health Insurance	60,756
Employee Meals	5,119
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	6,864
TOTAL (agree to Schedule V, line 22, col.8)	$ 424,600

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 31)	375
Patient Background Checks	
Illinois Council on Long Term Care	15,220
Miscellaneous Dues & Permits	3,584
Miscellaneous Inspections & Licenses	1,726
Allocated from Management Co.	88
From Schedule 21A	(3,212)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,781

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,604
Allocated from Management Co.	44
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,648

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing & Rehabilitation Center, Inc.
Provider # : 0039644
12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	70,518
Allocated from Real Estate Entity - Accounting	
- Legal	-
- Accounting	7,700
Allocated from Mangement Company	
- Legal	793
- Accounting	998
Total (Agree to Schedule V, Line 19, Column 8)	80,009

XIX. SUPPORT SCHEDULE
F. dues, Fees, Subscriptions and Promotions

Allocated from Real Estate Entity	266
Disallow Lobbying Expense	(3,478)
To Page 21. F.	(3,212)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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-$15,220**

(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. $ **859** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,119** 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**

(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