FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0034678

Facility Name: BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC.

Address: 150 N. 27TH STREET (Number) BELLEVILLE (City) 62226 (Zip Code)

County: SINCLAIR

Telephone Number: (618) 235-6600 **Fax #** (618) 235-7555

HFS ID Number:

Date of Initial License for Current Owners: 09/88

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: BOB KAGDA **Telephone Number:** (847) 675-3585
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 01/01/2011 to 12/31/2011 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) MARTIN WEISS
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 _____

	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	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	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			5,379	5,379	8
9	SNF/PED					9
10	ICF	39,205	2,379	1,546	43,130	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,205	2,379	6,925	48,509	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.44%

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 [X]

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 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 62 and days of care provided 5,379

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABII # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	251,932	23,694	8,955	284,581		284,581	6,873	291,454			1
2	Food Purchase		270,909		270,909		270,909	(326)	270,583			2
3	Housekeeping	182,258	42,167		224,425		224,425		224,425			3
4	Laundry	110,487	26,944	5,936	143,367		143,367		143,367			4
5	Heat and Other Utilities			153,540	153,540		153,540		153,540			5
6	Maintenance	87,846	59,362	20,135	167,343		167,343		167,343			6
7	Other (specify):*			27,992	27,992		27,992		27,992			7
8	TOTAL General Services	632,523	423,076	216,558	1,272,157		1,272,157	6,547	1,278,704			8
	B. Health Care and Programs											
9	Medical Director			23,000	23,000		23,000		23,000			9
10	Nursing and Medical Records	2,009,785	272,554	74,708	2,357,047		2,357,047	(12,838)	2,344,209			10
10a	Therapy			2,473	2,473		2,473		2,473			10a
11	Activities	142,920	7,436	1,930	152,286		152,286		152,286			11
12	Social Services	69,563	3,036	1,930	74,529		74,529		74,529			12
13	CNA Training											13
14	Program Transportation			389	389		389		389			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,222,268	283,026	104,430	2,609,724		2,609,724	(12,838)	2,596,886			16
	C. General Administration											
17	Administrative	81,892		300,000	381,892		381,892	87,726	469,618			17
18	Directors Fees											18
19	Professional Services			430,643	430,643		430,643	(293,351)	137,292			19
20	Dues, Fees, Subscriptions & Promotions			92,085	92,085		92,085	(41,117)	50,968			20
21	Clerical & General Office Expenses	171,516	25,100	45,191	241,807		241,807	26,067	267,874			21
22	Employee Benefits & Payroll Taxes			567,626	567,626		567,626		567,626			22
23	Inservice Training & Education			2,798	2,798		2,798	555	3,353			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			18,582	18,582		18,582	4,682	23,264			25
26	Insurance-Prop.Liab.Malpractice			177,408	177,408		177,408	15,543	192,951			26
27	Other (specify):*			189,000	189,000		189,000	(166,113)	22,887			27
28	TOTAL General Administration	253,408	25,100	1,823,333	2,101,841		2,101,841	(366,008)	1,735,833			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,108,199	731,202	2,144,321	5,983,722		5,983,722	(372,299)	5,611,423			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BELLEVILLE HEALTHCARE & REHABILITATIO #0034678 **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,127	
	REPAIRS & MAINTENANCE		828	
			0	8,955
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,936	
			0	5,936
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		22,645	
	ELECTRICITY		78,131	
	WATER		50,747	
	CABLE TV - LOBBY		2,017	
			0	153,540
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,716	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,369	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		8,050	
			0	
			0	
			0	
			0	20,135
7	**OTHER**			
	SCAVENGER		27,992	
	SECURITY SERVICE		0	
			0	
			0	27,992
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	23,000	23,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,438	
	PHARMACY CONSULTANT	XVIII B 39-2	1,270	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	71,000	
			0	
			0	74,708
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	812	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	647	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,014	
				2,473
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,930	
			0	1,930
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,930	
	SOCIAL WORKER	XVIII B 45-2	0	
				1,930
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, #0034678 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		389	389
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	300,000	300,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	40,925	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	89,718	
	BOKKEEPING/ADMINISTRATIVE SERVICE		300,000	430,643
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	35,939	
	EMPLOYEE WANT ADS	XIX F	28,524	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	12,123	
	LICENSES & PERMITS	XIX F	2,540	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,409	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,850	
	PATIENT BACKGROUND CHECKS	XIX F	3,700	
				92,085
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,557	
	EQUIPMENT REPAIR & MAINTENANCE		4,797	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	8,743	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		26,860	
	MESSENGER SERVICE		3,234	
			0	45,191

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	238,385	
	UNEMPLOYMENT COMPENSATION	XIX D	158,714	
	WORKERS COMPENSATION INSURANC	XIX D	82,673	
	HOSPITALIZATION INSURANCE	XIX D	79,730	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,124	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	567,626
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,798	
				2,798
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,582	
				18,582
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		177,408	
				177,408
27	**OTHER**			
	BAD DEBTS	VI 24	189,000	
				189,000

GRAND TOTAL COLUMN 3 OTHER **2,144,321**

BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC.
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	270,909
LESS SALES TAX	(326)
NET FOOD	270,583
TOTAL PATIENT CENSUS	48,509
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	145,527
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	145,527
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	145,527
NET FOOD	270,583
DIVIDE TOTAL MEALS/YEAR	145,527
COST PER MEAL	1.86
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CE #0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			56,155	56,155		56,155	144,732	200,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,600	15,600		15,600	214,927	230,527			32
33	Real Estate Taxes			3,018	3,018		3,018	62,102	65,120			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(474,566)	5,434			34
35	Rent-Equipment & Vehicles			23,858	23,858		23,858	12,100	35,958			35
36	Other (specify):*							20,623	20,623			36
37	**TOTAL Ownership**			578,631	578,631		578,631	(20,082)	558,549			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		220,871	650,000	870,871		870,871		870,871			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,220	83,220		83,220		83,220			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		220,871	733,220	954,091		954,091		954,091			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,108,199	952,073	3,456,172	7,516,444		7,516,444	(392,381)	7,124,063			45

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION C # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(9,852)	30		9
10	Interest and Other Investment Income	(494)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(326)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(8,743)	21		18
19	Entertainment		20		19
20	Contributions	(5,409)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(189,000)	27		24
25	Fund Raising, Advertising and Promotional	(35,939)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(37,023)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (286,786)		$	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)	(105,595)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (105,595)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (392,381)		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.		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC.

ID# 0034678

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ -37,023	21	1
2				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				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**	(37,023)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CE # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	6,873	0	0	0	0	0	0	0	0	6,873	1
2	Food Purchase	(326)	0	0	0	0	0	0	0	0	0	0	(326)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(326)	0	6,873	0	0	0	0	0	0	0	0	6,547	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(12,838)	0	0	0	0	0	0	0	0	(12,838)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	(12,838)	0	0	0	0	0	0	0	0	(12,838)	16
	C. General Administration													
17	Administrative	0	0	87,726	0	0	0	0	0	0	0	0	87,726	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(293,351)	0	0	0	0	0	0	0	0	(293,351)	19
20	Fees, Subscriptions & Promotions	(41,348)	0	231	0	0	0	0	0	0	0	0	(41,117)	20
21	Clerical & General Office Expenses	(45,766)	0	71,833	0	0	0	0	0	0	0	0	26,067	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	555	0	0	0	0	0	0	0	0	555	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	4,682	0	0	0	0	0	0	0	0	4,682	25
26	Insurance-Prop.Liab.Malpractice	0	13,401	2,142	0	0	0	0	0	0	0	0	15,543	26
27	Other (specify):*	(189,000)	0	22,887	0	0	0	0	0	0	0	0	(166,113)	27
28	TOTAL General Administration	(276,114)	13,401	(103,295)	0	0	0	0	0	0	0	0	(366,008)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(276,440)	13,401	(109,260)	0	0	0	0	0	0	0	0	(372,299)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CE **#** 0034678 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(9,852)	153,481	1,103	0	0	0	0	0	0	0	0	144,732	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(494)	215,421	0	0	0	0	0	0	0	0	0	214,927	32
33	Real Estate Taxes	0	62,102	0	0	0	0	0	0	0	0	0	62,102	33
34	Rent-Facility & Grounds	0	(480,000)	5,434	0	0	0	0	0	0	0	0	(474,566)	34
35	Rent-Equipment & Vehicles	0	0	12,100	0	0	0	0	0	0	0	0	12,100	35
36	Other (specify):*	0	20,623	0	0	0	0	0	0	0	0	0	20,623	36
37	**TOTAL Ownership**	(10,346)	(28,373)	18,637	0	0	0	0	0	0	0	0	(20,082)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(286,786)	(14,972)	(90,623)	0	0	0	0	0	0	0	0	(392,381)	45

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		ATRIUM HEALTH CARE & REHABILITATION		WEISS MGMT.		MGMT/CLERICAL
		CENTER OF CAHOKIA, LLC	CAHOKIA	GROUP, INC.	SKOKIE	
SEE ATTACHED SCHEDULE						
		PALOS HILLS HEALTHCARE, LLC	PALOS HILLS	LINCOLN		REAL ESTATE
				ASSOC., L.P.	SKOKIE	
		GENEVA NURSING & REHAB CENTER	GENEVA			

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	34	RENT	$ 480,000	LINCOLN ASSOCIATES, L.P.		$	$ (480,000)	1
2	V	30	DEPRECIATION				153,481	153,481	2
3	V	32	INTEREST EXPENSE				212,037	212,037	3
4	V	32	AMORT LOAN COST				3,384	3,384	4
5	V	33	REAL ESTATE TAXES				62,102	62,102	5
6	V	36	MIP INSURANCE				20,623	20,623	6
7	V	26	INSURANCE				13,401	13,401	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,000			$ 465,028	$ * (14,972)	14

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	10	NURSING CONSULTANT	$ 71,000	WEISS MANAGEMENT GROUP, INC.		$	$ (71,000)	15
16	V	17	MANAGEMENT FEES	300,000				(300,000)	16
17	V	19	ADMIN./BKKP. FEES	300,000				(300,000)	17
18	V								18
19	V								19
20	V								20
21	V	1	DIETARY SALARIES				6,873	6,873	21
22	V	10	NURSING SALARIES				58,162	58,162	22
23	V	17	ADMINISTRATIVE SALARIES				387,726	387,726	23
24	V	19	PROFESSIONAL FEES				6,649	6,649	24
25	V	20	LICENSES & PERMITS				231	231	25
26	V	21	OFFICE EXPENSES				71,833	71,833	26
27	V	23	SEMINARS				555	555	27
28	V	25	TRANSPORTATION STAFF				4,682	4,682	28
29	V	26	INSURANCE				2,142	2,142	29
30	V	27	EMPLOYEE BENEFITS				22,887	22,887	30
31	V	30	DEPRECIATION (SL)				1,103	1,103	31
32	V	34	OFFICE RENT				5,434	5,434	32
33	V	35	AUTO LEASE				12,100	12,100	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 671,000			$ 580,377	$ * (90,623)	39

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABI # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	MARTIN WEISS	PRESIDENT	ADMINISTRATO	45.10		20	50.00	SALARY	$ 115,514	17-7	1
2					SEE						2
3	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	ATTACHED	8	20.00	SALARY	147,431	17-7	3
4					SCHEDULE						4
5	NATAN WEISS	CFO	FINANCE/MGMT	8.39		10	25.00	SALARY	124,781	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 387,726		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 BELLEVILLE HEALTHCARE & REHABILITATION C # 0034678 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: WEISS MANAGEMENT GROUP, INC
Street Address: 3856 OAKTON STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 933-9200
Fax Number: (847) 933-9765

	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	1	DIETARY SALARIES	PATIENT CENSUS	158,674	4	$ 22,482	$ 22,482	48,509	$ 6,873	1
2	10	NURSING SALARIES	PATIENT CENSUS	158,674	4	190,250	190,250	48,509	58,162	2
3	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	158,674	4	1,268,260	1,268,260	48,509	387,726	3
4	19	PROFESSIONAL FEES	PATIENT CENSUS	158,674	4	21,748		48,509	6,649	4
5	20	LICENSES & PERMITS	PATIENT CENSUS	158,674	4	757		48,509	231	5
6	21	OFFICE EXPENSES	PATIENT CENSUS	158,674	4	234,967	179,529	48,509	71,833	6
7	23	SEMINARS	PATIENT CENSUS	158,674	4	1,816		48,509	555	7
8	25	TRANSPORTATION STAFF	PATIENT CENSUS	158,674	4	15,315		48,509	4,682	8
9	26	INSURANCE	PATIENT CENSUS	158,674	4	7,007		48,509	2,142	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	158,674	4	74,863		48,509	22,887	10
11	30	DEPRECIATION (SL)	PATIENT CENSUS	158,674	4	3,607		48,509	1,103	11
12	34	OFFICE RENT	PATIENT CENSUS	158,674	4	17,775		48,509	5,434	12
13	35	AUTO LEASE	PATIENT CENSUS	158,674	4	39,578		48,509	12,100	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					$ 1,898,425	$ 1,660,521		$ 580,377	25

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABII # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	RELATED PARTY: THE LINCOLN ASSOCIATION, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$31,065.72	04/04	4,528,900	4,094,314	04/39	5.1400	212,037	2
3	AMORT LOAN COST		X	AMORT OVER LIFE			118,455	92,229			3,384	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND					PRIME+	11,687	6
7		X		INSURANCE FINANCING							3,913	7
8												8
9	TOTAL Facility Related				$31,065.72		$ 4,647,355	$ 4,186,543			$ 231,021	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,647,355	$ 4,186,543			$ 231,021	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 20,623 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.)

** 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 BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 51,532	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.)		$ 59,552	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,020	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 57,100	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.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **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.		$ 65,120	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	47,114	8
	2007	48,929	9
	2008	51,185	10
	2009	53,890	11
	2010	59,552	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELLEVILLE HEALTHCARE & REHABILITATION CEN COUNTY SINCLAIR

FACILITY IDPH LICENSE NUMBER 0034678

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20.0-204-015	NURSING HOME	$ 3,017.76	$ 3,017.76
2.	08-20.0-210-029	NURSING HOME	$ 55,135.64	$ 55,135.64
3.	08-20.0-207-025	NURSING HOME	$ 1,151.22	$ 1,151.22
4.	08-20.0-210-028	NURSING HOME	$ 247.30	$ 247.30
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 59,551.92	$ 59,551.92

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,241 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

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? [X] (a) Own the Equipment [ ] (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).

N/A

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	NURSING HOME	3+ACRES	1987	$ 148,649	1
2	PARKING LOT	2+ACRES	2005	50,000	2
3	TOTALS	#VALUE!		$ 198,649	3

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	152		1988		$ 2,011,351	$ 63,852	31.5	$ 63,852	$	$ 1,461,689	4
5			2003		1,249,221	45,426	27.5	45,426		384,228	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1990	11,158	354	31.5	354		7,528	9
10	VARIOUS			1993	6,676	171	39	171		3,950	10
11	VARIOUS			1994	7,797	200	39	200		4,458	11
12	VARIOUS			1995	13,072	335	39	335		6,592	12
13	CARPET			1996	907	23	39	23		397	13
14	BILLBOARD			1996	900	23	39	23		400	14
15	SMOKE DETECTORS			1996	602	15	39	15		265	15
16	PARKING LOT			1996	8,006	205	39	205		3,665	16
17	AWNING			1996	905	23	39	23		415	17
18	CARPETING			1996	1,512	39	39	39		716	18
19	DOOR LOCKS			1997	2,100	54	39	54		868	19
20	WALL PAPER			1997	2,012	52	39	52		846	20
21	HANDRAIL			1997	3,217	83	39	83		1,274	21
22	FIRE ALARM SYSTEM			1998	11,636	298	39	298		4,165	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION			1998	9,227	236	39	236		3,305	23
24	PAINTING/WALLPAPERING			1998	2,988	77	39	77		1,076	24
25	REPLACE PVC PIPE IN BASEMENT			1998	1,074	28	39	28		391	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD			1999	6,144	158	39	158		1,664	26
27	INSTALLED A NEW DURO-LAST ROOF			1999	56,400	1,446	39	1,446		15,178	27
28	WALLPAPER			2000	14,896	382	39	382		4,947	28
29	SEWER LINE REPAIR			2000	11,743	301	39	301		3,455	29
30	AIR CONDITIONING UNITS			2000	8,848	227	39	227		2,605	30
31	CONDENSING UNIT ON FREEZER			2000	2,693	69	39	69		795	31
32	NEW NURSES STATION			2000	20,379	522	39	522		6,013	32
33	FIRE ALARM SYSTEM			2000	1,826	47	39	47		541	33
34	HOT WATER SYSTEM			2000	3,849	99	20	99		2,153	34
35	TILED FLOORS			2000	54,185	1,389	39	1,389		15,983	35
36	REMODELING OF BATHROOMS			2000	18,490	474	39	474		5,449	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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	$ 13,369	$	20	$ 668	$ 668	$ 10,006	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		13,714	38
39	ROOF	2001	47,500	1,727	27.5	1,727		18,134	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		3,506	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		4,662	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		4,336	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		20,821	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		14,344	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159		20	1,558	1,558	15,580	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		2,418	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		6,010	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTRY	2002	7,245	263	27.5	263		2,553	48
49	LANDSCAPING	2004	7,759		15	517	517	3,813	49
50	REPLACEMENT WINDOWS	2004	32,853		20	1,643	1,643	13,144	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270		20	314	314	2,512	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250		20	5,263	5,263	42,104	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		749	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		594	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		7,144	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		2,221	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		1,976	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		9,274	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		4,385	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906	1,791	5	1,791		17,906	60
61	AIR CONDITIONERS	2007	7,968	918	5	918		7,510	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	2,084	27.5	2,084		9,291	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		1,453	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		633	64
65	PAINTING	2007	9,986	1,150	5	1,150		9,410	65
66	GARDEN	2007	60,172	2,188	15	4,012	1,824	15,956	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		694	67
68	PAINTING - 30 ROOMS	2008	2,550	294	5	294		2,110	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	105	27.5	105		398	69
70	TOTAL (lines 4 thru 69)		$ 4,265,246	$ 138,601		$ 150,388	$ 11,787	$ 2,214,372	70

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 4,265,246	$ 138,601		$ 150,388	$ 11,787	$ 2,214,372	1
2	GRADING PARKING LOT	2008	1,473	98	15	98		368	2
3	DOOR GUARDS - VARIOUS DIFFERENT AREAS	2008	4,672	170	27.5	170		616	3
4	INSTALL 2 HOLLOW METAL DOORS	2009	1,599	58	27.5	58		157	4
5	WALL AIR CONDITIONS	2009	5,187	996	5	996		3,693	5
6	INSTALL NEW COMPRESSOR,CRANK CASE HEATER	2009	3,195	116	27.5	116		305	6
7	INSTALL SIDEWALL EXHAUST DUST FAN	2009	8,048	293	27.5	293		745	7
8	INSTALL TON 1,1/2 ROCK ON PARKING LOT	2009	1,865	124	15	124		2,051	8
9	CERAMIC TILE, HANDRAILS, CUSTOM NURSING STATION	2009	114,376	4,159	27.5	4,159		10,917	9
10	WALLCOVERING, CARPET, PAINTING, BLINDS, CURTAINS	2009	29,344	5,634	5	5,634		20,893	10
11	WALL AIR CONDITIONS	2010	4,581	733	5	733		3,482	11
12	INSTALL STEEL DOOR	2010	10,694	389	27.5	389		535	12
13	FIRE PROTECTION WORK-SPRINKLERS PHASE 1	2010	97,653	3,551	27.5	3,551		3,995	13
14	FIRE PROTECTION WORK-SPRINKLERS PHASE 2	2011	97,652	444	27.5	444		444	14
15	WING CORRIDORS-FLOORING,WALLCOVERING,	2011	67,587	2,356	27.5	2,356		2,356	15
16	HANDRAILS,BUNPER GUARDS,SIGNAGE,WALL PROTECTION								16
17	INSTALL NEW CARRIER RTU	2011	4,517	89	27.5	89		89	17
18	PAINTING-100 & 200 HALL, LODGING, NURSES STATION	2011	44,405	2,220	5	2,220		2,220	18
19	WALL AIR CONDITIONS	2011	7,698	7,698	5	1,540	(6,158)	1,540	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	TOTAL (lines 1 thru 33)		$ 4,769,792	$ 167,729		$ 173,358	$ 5,629	$ 2,268,778	34

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATI # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 294,217	$ 24,049	$ 23,547	$ (502)	3-10 YR	$ 180,093	71
72	Current Year Purchases	15,767	15,767	788	(14,979)		788	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		3,194	3,194				74
75	TOTALS	$ 309,984	$ 43,010	$ 27,529	$ (15,481)		$ 180,881	75

D. Vehicle Costs. (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	FACILITY	2005 FORD ECONOCARE	2005	$ 41,500	$	$	$	5	$ 41,500	76
77										77
78										78
79										79
80	TOTALS			$ 41,500	$	$	$		$ 41,500	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)	$	5,319,925	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	210,739	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	200,887	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(9,852)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,491,159	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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 BELLEVILLE HEALTHCARE & REHABILITATION CE# 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 23,858 Description: SEE SCHEDULE ATTACHED
(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					18
19					19
20					20
21	TOTAL		$	$	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.

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC. # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

   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 ____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	39-3	hrs	$		$ 265,083	$		$ 265,083	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			101,853			101,853	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			283,064			283,064	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				202,104		202,104	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY	39-2					9,457		9,457	12
13	Other (specify): LABORATORY	39-2					9,310		9,310	13
14	TOTAL			$		$ 650,000	$ 220,871		$ 870,871	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.

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CE # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 123,179	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 189,000)	2,402,616		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,542		6
7	Other Prepaid Expenses	2,442		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,661,779	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	141,472		15
16	Equipment, at Historical Cost	351,484		16
17	Accumulated Depreciation (book methods)	(363,465)		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):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 253,517	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,915,296	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 734,733	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	581,080		29
30	Accrued Salaries Payable	167,356		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,336		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,508,505	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LINCOLN ASSOCIATES	463,139		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 463,139	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,971,644	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 943,652	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,915,296	$	48

***(See instructions.)**

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, I # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 394,404	1
2	Restatements (describe):		2
3	**PRIOR YEAR ADJUSTMENT**	(1,265)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 393,139	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	550,513	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 550,513	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)**	$ 943,652	24 *

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITAT # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 6,815,078	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,815,078	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,249,642	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,249,642	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	1,359	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	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,359	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	494	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 494	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	384	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 384	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,066,957	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,272,157	31
32	Health Care	2,609,724	32
33	General Administration	2,101,841	33
	B. Capital Expense		
34	Ownership	578,631	34
	C. Ancillary Expense		
35	Special Cost Centers	870,871	35
36	Provider Participation Fee	83,220	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,516,444	40
41	**Income before Income Taxes (line 30 minus line 40)****	550,513	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 550,513	43

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

****** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

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

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

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CE # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,992	2,080	$ 70,754	$ 34.02	1
2	Assistant Director of Nursing	2,952	3,024	73,736	24.38	2
3	Registered Nurses	9,350	9,738	247,497	25.42	3
4	Licensed Practical Nurses	28,771	29,612	588,263	19.87	4
5	CNAs & Orderlies	89,239	91,188	858,272	9.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,631	15,087	142,920	9.47	10
11	Social Service Workers	5,152	5,622	69,563	12.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,563	26,986	251,932	9.34	15
16	Dishwashers					16
17	Maintenance Workers	5,502	5,795	87,846	15.16	17
18	Housekeepers	18,527	19,280	182,258	9.45	18
19	Laundry	12,932	13,363	110,487	8.27	19
20	Administrator	1,900	2,013	81,892	40.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,904	12,322	171,516	13.92	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	3,428	3,803	40,639	10.69	31
32	Other Health Ca Care Plan Coord	5,944	6,272	130,624	20.83	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	237,787	246,185	$ 3,108,199 *	$ 12.63	34

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

** See instructions.

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	M	$ 8,127	1-3	35
36	Medical Director	O	23,000	9-3	36
37	Medical Records Consultant	N	2,438	10-3	37
38	Nurse Consultant	T	71,000	10-3	38
39	Pharmacist Consultant	H	1,270	10-3	39
40	Physical Therapy Consultant	L	812	10a-3	40
41	Occupational Therapy Consultant	Y	647	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	1,014	10a-3	43
44	Activity Consultant	E	1,930	11-3	44
45	Social Service Consultant	E	1,930	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 112,168		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATI # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRISTOPHER RAYBORN	ADMINISTRATOR	0	$ 49,684
DEBORAH CUTRIGHT	ADMINISTRATOR	0	32,208
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,892

B. Administrative - Other

Description		Amount
WEISS MANAGEMENR GROUP	MANAGEMENT FEES	$ 300,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 300,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		430,643
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 430,643

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,673
Unemployment Compensation Insurance	158,714
FICA Taxes	238,385
Employee Health Insurance	79,730
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	8,124
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 567,626

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	28,524
Health Care Worker Background Check	3,850
(Indicate # of checks performed 385)	
Patient Background Checks 370	3,700
TRUST/FRANCHISE/CONTRIB/ETC	5,409
MARKETING/ADV/PROMO	35,939
LICENSES/DUES/SUBSCRIPTIONS	12,673
MGMT CO ALLOC	231
TRUST/FRANCHISE/CONTRIB/ETC	(5,409)
Less: Public Relations Expense	(0)
Non-allowable advertising	(35,939)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,968

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION C # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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													
4													
5													
6													
7													
8							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BELLEVILLE HEALTHCARE & REHABILITATION CENTER, IN # 0034678 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 $11,778**

(3) Did the nursing home make political contributions or payments to a politica 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?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,253** Line **10-2**

(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.

(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 fo 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen during this cost report period. $ **83,220**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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 fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe 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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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