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.

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

I. IDPH License ID Number: 0039644

Facility Name: Caseyville Nursing & Rehabilitation Center, Inc.

Address: 601 West Lincoln (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 01/01/2011 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)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' PREPARATION 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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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 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	624	712	4,360	5,696	8
9	SNF/PED					9
10	ICF	27,655	10,551		38,206	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,279	11,263	4,360	43,902	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.19%

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 4,360

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, I # 0039644 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	256,134	20,716	4,136	280,986		280,986		280,986			1
2	Food Purchase		274,936		274,936		274,936	(6,563)	268,373			2
3	Housekeeping	153,741	66,450		220,191		220,191	112	220,303			3
4	Laundry	131,134	7,188		138,322		138,322		138,322			4
5	Heat and Other Utilities			171,266	171,266		171,266	1,430	172,696			5
6	Maintenance	121,986	72,607	12,654	207,247		207,247	562	207,809			6
7	Other (specify):*											7
8	TOTAL General Services	662,995	441,897	188,056	1,292,948		1,292,948	(4,459)	1,288,489			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,838,405	68,074	3,381	1,909,860		1,909,860	(6)	1,909,854			10
10a	Therapy			735,945	735,945		735,945		735,945			10a
11	Activities	78,599	11,239		89,838		89,838		89,838			11
12	Social Services	57,412		30	57,442		57,442		57,442			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,974,416	79,313	744,156	2,797,885		2,797,885	(6)	2,797,879			16
	C. General Administration											
17	Administrative	82,035		188,400	270,435		270,435	(38,567)	231,868			17
18	Directors Fees											18
19	Professional Services			122,664	122,664		122,664	7,083	129,747			19
20	Dues, Fees, Subscriptions & Promotions			7,199	7,199		7,199	622	7,821			20
21	Clerical & General Office Expenses	420,333		44,662	464,995		464,995	56,986	521,981			21
22	Employee Benefits & Payroll Taxes			442,276	442,276		442,276	5,382	447,658			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,845	1,845		1,845	23	1,868			24
25	Other Admin. Staff Transportation			46,520	46,520		46,520	2,230	48,750			25
26	Insurance-Prop.Liab.Malpractice			76,143	76,143		76,143	6,005	82,148			26
27	Other (specify):* Mgmt Alloc of Benefit							17,745	17,745			27
28	TOTAL General Administration	502,368		929,709	1,432,077		1,432,077	57,509	1,489,586			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,139,779	521,210	1,861,921	5,522,910		5,522,910	53,044	5,575,954			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 Number Caseyville Nursing & Rehabilitation Center, Inc. #0039644 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			89,436	89,436		89,436	122,474	211,910			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							357,448	357,448			32
33	Real Estate Taxes							75,735	75,735			33
34	Rent-Facility & Grounds			616,000	616,000		616,000	(616,000)				34
35	Rent-Equipment & Vehicles			193	193		193	1,105	1,298			35
36	Other (specify):* **Mortgage Insurance**							29,422	29,422			36
37	**TOTAL Ownership**			705,629	705,629		705,629	(29,816)	675,813			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,128	14,738	163,866		163,866	(14,738)	149,128			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-Allow Costs**			75,840	75,840		75,840	(75,840)				43
44	**TOTAL Special Cost Centers**		149,128	172,703	321,831		321,831	(90,578)	231,253			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,139,779	670,338	2,740,253	6,550,370		6,550,370	(67,350)	6,483,020			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 Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	(36,944)	30		9
10	Interest and Other Investment Income	(20,909)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(458)	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	(20,605)	43		18
19	Entertainment				19
20	Contributions	(900)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,182)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,119)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,963)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(29,533)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (149,613)		$	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)	82,263		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 82,263		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,350)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Caseyville Nursing & Rehabilitation Center, Inc.

ID# 0039644

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (8,451)	43	1
2	X Ray Expense Med A	(6,344)	43	2
3	Managed Care Cost	(14,738)	39	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	(29,533)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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%	$ 6,900	$ 6,900	1
2	V	26	Insurance		Caseyville Property LLC	100.00%	5,599	5,599	2
3	V	30	Depreciation		Caseyville Property LLC	100.00%	155,720	155,720	3
4	V	32	Interest		Caseyville Property LLC	100.00%	373,656	373,656	4
5	V	32	Interest Income		Caseyville Property LLC	100.00%	(83)	(83)	5
6	V	33	Real Estate Taxes		Caseyville Property LLC	100.00%	72,184	72,184	6
7	V	34	Rent	616,000	Caseyville Property LLC	100.00%		(616,000)	7
8	V	36	Mortgage Insurance		Caseyville Property LLC	100.00%	29,422	29,422	8
9	V	32	Amortization		Caseyville Property LLC	100.00%	4,784	4,784	9
10	V	20	License Dues Fees Subscriptions		Caseyville Property LLC	100.00%	501	501	10
11	V								11
12	V								12
13	V								13
14	Total			$ 616,000			$ 648,683	$ * 32,683	14

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	Abraham J Stern	4.67	Cahokia Nursing and Rehab	Cahokia	Shabbona Supportive I	Shabbona	Supportive Living F	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	S.W. Management Co.	Skokie	Bookkeeping/Manag	2
3	Sheldon Wolfe	23.67	Shabbona Healthcare Center	Shabbona	S&E Medical Supply C	Skokie	Medical Supplies	3
4	Ronnie Klein as Trustee	5.00			*SFO Associates	Skokie	Finance Company	4
5	Maurice Aaron	4.67						5
6	Michael Klein Revocable Trust	2.00			* This entity only relates to Shabbona Healthcare Center,			6
7	Wanda Bowling	0.67	Rosewood Health and Rehab Center	Independence, MO	Franklin Grove Living and Rehab, and Oregon Living			7
8	Michael A Klein as Custodian	6.67	Beauvais Manor Healthcare and Rehab	St. Louis, MO	and Rehab			8
9	Michael A Klein as Trustee	6.67	Hillside Manor Healthcare and Rehab	St. Louis, MO				9
10	Kenneth Klein	5.00	Rancho Manor Healthcare Center	Florissant, MO				10
11	Susan Stern	4.67						11
12	Jonathan B Stern 2001 Trust	1.56						12
13	Todd A. Stern 2001 Trust	1.56						13
14	Evan M. Stern	1.56						14
15	Ora Aaron	4.67						15
16	Moshe Herman	0.67						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 Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	2	Food	$	SW Management Co. (January-February)	100.00%	$ 26	$ 26	15
16	V	3	Housekeeping		SW Management Co. (January-February)	100.00%	15	15	16
17	V	5	Heat and Other Utilties		SW Management Co. (January-February)	100.00%	194	194	17
18	V	6	Maintenance		SW Management Co. (January-February)	100.00%	76	76	18
19	V	17	Administrative	31,400	SW Management Co. (January-February)	100.00%	17,521	(13,879)	19
20	V	19	Professional Services		SW Management Co. (January-February)	100.00%	185	185	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (January-February)	100.00%	16	16	21
22	V	21	Clerical & General Office Expense		SW Management Co. (January-February)	100.00%	6,782	6,782	22
23	V	24	Travel and Seminar		SW Management Co. (January-February)	100.00%	3	3	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (January-February)	100.00%	302	302	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (January-February)	100.00%	55	55	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (January-February)	100.00%	2,405	2,405	26
27	V	30	Depreciation		SW Management Co. (January-February)	100.00%	616	616	27
28	V	32	Interest		SW Management Co. (January-February)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (January-February)	100.00%	481	481	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (January-February)	100.00%	150	150	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			$ 31,400			$ 28,827	$ * (2,573)	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	2	Food	$	SW Management Co. (March)	100.00%	$ 15	$ 15	15
16	V	3	Housekeeping		SW Management Co. (March)	100.00%	9	9	16
17	V	5	Heat and Other Utilties		SW Management Co. (March)	100.00%	114	114	17
18	V	6	Maintenance		SW Management Co. (March)	100.00%	45	45	18
19	V	17	Administrative	15,700	SW Management Co. (March)	100.00%	9,244	(6,456)	19
20	V	19	Professional Services		SW Management Co. (March)	100.00%	109	109	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (March)	100.00%	10	10	21
22	V	21	Clerical & General Office Expense		SW Management Co. (March)	100.00%	4,638	4,638	22
23	V	24	Travel and Seminar		SW Management Co. (March)	100.00%	2	2	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (March)	100.00%	178	178	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (March)	100.00%	32	32	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (March)	100.00%	1,417	1,417	26
27	V	30	Depreciation		SW Management Co. (March)	100.00%	308	308	27
28	V	32	Interest		SW Management Co. (March)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (March)	100.00%	284	284	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (March)	100.00%	88	88	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			$ 15,700			$ 16,493	$ * 793	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	2	Food	$	SW Management Co. (April thru June)	100.00%	$ 49	$ 49	15
16	V	3	Housekeeping		SW Management Co. (April thru June)	100.00%	29	29	16
17	V	5	Heat and Other Utilties		SW Management Co. (April thru June)	100.00%	374	374	17
18	V	6	Maintenance		SW Management Co. (April thru June)	100.00%	147	147	18
19	V	17	Administrative	47,100	SW Management Co. (April thru June)	100.00%	29,181	(17,919)	19
20	V	19	Professional Services		SW Management Co. (April thru June)	100.00%	357	357	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (April thru June)	100.00%	32	32	21
22	V	21	Clerical & General Office Expense		SW Management Co. (April thru June)	100.00%	15,188	15,188	22
23	V	24	Travel and Seminar		SW Management Co. (April thru June)	100.00%	6	6	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (April thru June)	100.00%	583	583	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (April thru June)	100.00%	106	106	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (April thru June)	100.00%	4,641	4,641	26
27	V	30	Depreciation		SW Management Co. (April thru June)	100.00%	925	925	27
28	V	32	Interest		SW Management Co. (April thru June)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (April thru June)	100.00%	929	929	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (April thru June)	100.00%	289	289	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			$ 47,100			$ 52,836	$ * 5,736	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	2	Food	$	SW Management Co. (July-August)	100.00%	$ 33	$ 33	15
16	V	3	Housekeeping		SW Management Co. (July-August)	100.00%	20	20	16
17	V	5	Heat and Other Utilties		SW Management Co. (July-August)	100.00%	249	249	17
18	V	6	Maintenance		SW Management Co. (July-August)	100.00%	98	98	18
19	V	17	Administrative	31,400	SW Management Co. (July-August)	100.00%	19,453	(11,947)	19
20	V	19	Professional Services		SW Management Co. (July-August)	100.00%	238	238	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (July-August)	100.00%	21	21	21
22	V	21	Clerical & General Office Expense		SW Management Co. (July-August)	100.00%	10,126	10,126	22
23	V	24	Travel and Seminar		SW Management Co. (July-August)	100.00%	4	4	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (July-August)	100.00%	389	389	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (July-August)	100.00%	71	71	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (July-August)	100.00%	3,094	3,094	26
27	V	30	Depreciation		SW Management Co. (July-August)	100.00%	616	616	27
28	V	32	Interest		SW Management Co. (July-August)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (July-August)	100.00%	619	619	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (July-August)	100.00%	193	193	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			$ 31,400			$ 35,224	$ * 3,824	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	2	Food	$	SW Management Co. (September thru December)	100.00%	$ 66	$ 66	15
16	V	3	Housekeeping		SW Management Co. (September thru December)	100.00%	39	39	16
17	V	5	Heat and Other Utilties		SW Management Co. (September thru December)	100.00%	499	499	17
18	V	6	Maintenance		SW Management Co. (September thru December)	100.00%	196	196	18
19	V	17	Administrative	62,800	SW Management Co. (September thru December)	100.00%	74,434	11,634	19
20	V	19	Professional Services		SW Management Co. (September thru December)	100.00%	476	476	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (September thru December)	100.00%	42	42	21
22	V	21	Clerical & General Office Expense		SW Management Co. (September thru December)	100.00%	20,252	20,252	22
23	V	24	Travel and Seminar		SW Management Co. (September thru December)	100.00%	8	8	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (September thru December)	100.00%	778	778	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (September thru December)	100.00%	142	142	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (September thru December)	100.00%	6,188	6,188	26
27	V	30	Depreciation		SW Management Co. (September thru December)	100.00%	1,233	1,233	27
28	V	32	Interest		SW Management Co. (September thru December)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (September thru December)	100.00%	1,238	1,238	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (September thru December)	100.00%	385	385	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			$ 62,800			$ 105,976	$ * 43,176	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	2	Food	$ 9,986	S & E Medical Supply Co.	100.00%	$ 8,616	$ (1,370)	15
16	V	10	Medical Supplies	2,812	S & E Medical Supply Co.	100.00%	2,806	(6)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,798			$ 11,422	$ * (1,376)	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, # 0039644 Report Period Beginning: 01/01/2011 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	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.14	Salary	$ 14,500	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	15	37.50	Salary & Fees	136,125	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	7.14	Salary	14,500	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	$ 165,125		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, Inc. # 0039644 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: SW Management Co. (January-February)
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	124,018	12	$ 358	$	8,850	$ 26	1
2	3	Housekeeping	Bed Days Available	124,018	12	213		8,850	15	2
3	5	Heat and Other Utilities	Bed Days Available	124,018	12	2,716		8,850	194	3
4	6	Maintenance	Bed Days Available	124,018	12	1,066		8,850	76	4
5	19	Professional Services	Bed Days Available	124,018	12	2,591		8,850	185	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	124,018	12	229		8,850	16	6
7	21	Clerical & General Office Exp	Bed Days Available	124,018	12	95,042	95,042	8,850	6,782	7
8	24	Travel and Seminar	Bed Days Available	124,018	12	42		8,850	3	8
9	25	Other Admin. Staff Transport	Bed Days Available	124,018	12	4,236		8,850	302	9
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	124,018	12	772		8,850	55	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	124,018	12	33,703		8,850	2,405	11
12	32	Interest	Bed Days Available	124,018	12			8,850	0	12
13	33	Real Estate Taxes	Bed Days Available	124,018	12	6,744		8,850	481	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	124,018	12	2,099		8,850	150	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	3	2,417	17
18	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	3	2,417	18
19	17	Administrative	Avg. Hours Worked	40	3	33,833	33,833	15	12,687	19
20										20
21	30	Depreciation	Direct Cost	6,938					616	21
22										22
23										23
24										24
25	TOTALS					$ 251,310	$ 196,541		$ 28,827	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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: SW Management Co. (March)
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	55,304	11	$ 179	$	4,650	$ 15	1
2	3	Housekeeping	Bed Days Available	55,304	11	106		4,650	9	2
3	5	Heat and Other Utilities	Bed Days Available	55,304	11	1,358		4,650	114	3
4	6	Maintenance	Bed Days Available	55,304	11	532		4,650	45	4
5	19	Professional Services	Bed Days Available	55,304	11	1,294		4,650	109	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	55,304	11	115		4,650	10	6
7	21	Clerical & General Office Exp	Bed Days Available	55,304	11	55,153	47,522	4,650	4,638	7
8	24	Travel and Seminar	Bed Days Available	55,304	11	22		4,650	2	8
9	25	Other Admin. Staff Transport	Bed Days Available	55,304	11	2,118		4,650	178	9
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	55,304	11	386		4,650	32	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	55,304	11	16,851		4,650	1,417	11
12	32	Interest	Bed Days Available	55,304	11			4,650		12
13	33	Real Estate Taxes	Bed Days Available	55,304	11	3,372		4,650	284	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	55,304	11	1,050		4,650	88	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	35	11	16,917	16,917	3	1,450	17
18	17	Administrative	Avg. Hours Worked	35	11	16,917	16,917	3	1,450	18
19	17	Administrative	Avg. Hours Worked	40	3	16,917	16,917	15	6,344	19
20										20
21	30	Depreciation	Direct Cost	3,469					308	21
22										22
23										23
24										24
25	TOTALS					$ 133,287	$ 98,273		$ 16,493	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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: SW Management Co. (April thru June)
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	148,694	10	$ 537	$	13,650	$ 49	1
2	3	Housekeeping	Bed Days Available	148,694	10	320		13,650	29	2
3	5	Heat and Other Utilities	Bed Days Available	148,694	10	4,074		13,650	374	3
4	6	Maintenance	Bed Days Available	148,694	10	1,599		13,650	147	4
5	19	Professional Services	Bed Days Available	148,694	10	3,896		13,650	357	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	148,694	10	344		13,650	32	6
7	21	Clerical & General Office Exp	Bed Days Available	148,694	10	165,455	142,564	13,650	15,188	7
8	24	Travel and Seminar	Bed Days Available	148,694	10	64		13,650	6	8
9	25	Other Admin. Staff Transport	Bed Days Available	148,694	10	6,354		13,650	583	9
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	148,694	10	1,158		13,650	106	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	148,694	10	50,553		13,650	4,641	11
12	32	Interest	Bed Days Available	148,694	10			13,650		12
13	33	Real Estate Taxes	Bed Days Available	148,694	10	10,116		13,650	929	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	148,694	10	3,149		13,650	289	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	50,750	50,750	3	5,075	17
18	17	Administrative	Avg. Hours Worked	30	10	50,750	50,750	3	5,075	18
19	17	Administrative	Avg. Hours Worked	40	3	50,750	50,750	15	19,031	19
20										20
21	30	Depreciation	Direct Cost	10,408					925	21
22										22
23										23
24										24
25	TOTALS					$ 399,869	$ 294,814		$ 52,836	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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: SW Management Co. (July-August)
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	101,308	10	$ 358	$	9,300	$ 33	1
2	3	Housekeeping	Bed Days Available	101,308	10	213		9,300	20	2
3	5	Heat and Other Utilities	Bed Days Available	101,308	10	2,716		9,300	249	3
4	6	Maintenance	Bed Days Available	101,308	10	1,066		9,300	98	4
5	19	Professional Services	Bed Days Available	101,308	10	2,591		9,300	238	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	101,308	10	229		9,300	21	6
7	21	Clerical & General Office Exp	Bed Days Available	101,308	10	110,303	95,042	9,300	10,126	7
8	24	Travel and Seminar	Bed Days Available	101,308	10	42		9,300	4	8
9	25	Other Admin. Staff Transport	Bed Days Available	101,308	10	4,236		9,300	389	9
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	101,308	10	772		9,300	71	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	101,308	10	33,703		9,300	3,094	11
12	32	Interest	Bed Days Available	101,308	10			9,300		12
13	33	Real Estate Taxes	Bed Days Available	101,308	10	6,744		9,300	619	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	101,308	10	2,099		9,300	193	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	17
18	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	18
19	17	Administrative	Avg. Hours Worked	40	3	33,833	33,833	15	12,687	19
20										20
21	30	Depreciation	Direct Cost	6,938					616	21
22										22
23										23
24										24
25	TOTALS					$ 266,571	$ 196,541		$ 35,224	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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: SW Management Co. (September thru December
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	199,348	10	$ 716	$	18,300	$ 66	1
2	3	Housekeeping	Bed Days Available	199,348	10	426		18,300	39	2
3	5	Heat and Other Utilities	Bed Days Available	199,348	10	5,432		18,300	499	3
4	6	Maintenance	Bed Days Available	199,348	10	2,131		18,300	196	4
5	19	Professional Services	Bed Days Available	199,348	10	5,181		18,300	476	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	199,348	10	458		18,300	42	6
7	21	Clerical & General Office Exp	Bed Days Available	199,348	10	220,606	190,085	18,300	20,252	7
8	24	Travel and Seminar	Bed Days Available	199,348	10	86		18,300	8	8
9	25	Other Admin. Staff Transport	Bed Days Available	199,348	10	8,472		18,300	778	9
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	199,348	10	1,543		18,300	142	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	199,348	10	67,405		18,300	6,188	11
12	32	Interest	Bed Days Available	199,348	10			18,300		12
13	33	Real Estate Taxes	Bed Days Available	199,348	10	13,488		18,300	1,238	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	199,348	10	4,198		18,300	385	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	67,667	67,667	3	6,767	17
18	17	Administrative	Avg. Hours Worked	30	10			3		18
19	17	Administrative	Avg. Hours Worked	15	1	67,667	67,667	15	67,667	19
20										20
21	30	Depreciation	Direct Cost	13,877					1,233	21
22										22
23										23
24										24
25	TOTALS					$ 465,476	$ 325,419		$ 105,976	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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: 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			$	$		$ 8,616	1
2	10	Medical Supplies	Direct Cost						2,806	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 11,422	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, I # 0039644 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	Heartland Bank		X	Mortgage	$38,896.00	11/27/01	$ 6,814,000	$ 5,841,416	12/1/36	0.0635	$ 373,656	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	$ 5,841,416			$ 378,440	9
	B. Non-Facility Related*											
10												10
11							Interest income offset fromNursing Home				(20,909)	11
12							Interest income offset from Real Estate Entity				(83)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (20,992)	14
15	TOTALS (line 9+line14)						$ 6,814,000	$ 5,841,416			$ 357,448	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.)**

**** 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, Inc. # 0039644 **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.**	$ 76,800	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.)	**2010**	$ 73,391	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,409)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,593	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.**	$ 662	5
	Allocated from Management Co.		
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.)**		$ 2,889	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 75,735	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	94,408	8
	2007	96,110	9
	2008	71,359	10
	2009	74,520	11
	2010	73,391	12

2011 Tax Accrual = $73,391 * 1.03 = 75,593.

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 Caseyville Nursing & Rehabilitation Center, Inc. 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 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.	03-07.0-300-005	Long Term Care Property	$ 73,391.00	$ 73,391.00
2.	10-28-412-049-0000	SW Management Allocation	$ 33,410.00	$ 2,889.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 106,801.00	$ 76,280.00

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 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 Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	150		2001		$ 5,265,179	$	39	$ 146,726	$ 146,726	$ 1,472,832	4
5											5
6											6
7	Management Allocation				38,454			1,099	1,099	18,299	7
8											8
	Improvement Type**										
9	Various			1994	22,304	58	20	1,115	1,057	19,222	9
10	Various			1995	52,604	107	20	2,630	2,523	43,441	10
11	Various			1996	2,492		20	125	125	2,059	11
12	Various			1997	11,349	43	20	567	524	8,230	12
13	Various			1998	14,511	227	20	726	499	10,650	13
14	Various			1999	83,394	613	20	4,170	3,557	52,189	14
15	Parking Lot			2000	2,830	167	20	142	(25)	1,606	15
16	Sprinkler System			2000	3,385	87	20	169	82	1,974	16
17	Sprinkler System			2000	5,820	149	20	291	142	3,419	17
18	A/C Repairs			2000	1,018		10			1,018	18
19	Ac Repairs			2000	1,102		20	55	55	638	19
20	Draperies			2000	1,052		20	53	53	593	20
21	Carpeting			2000	1,578		20	79	79	922	21
22	Air Handler			2000	1,786		20	89	89	1,027	22
23	Air Conditioner			2000	1,963		7			1,324	23
24	Air Handler			2000	1,241		20	62	62	713	24
25	Air Conditioner			2000	1,029		20	51	51	598	25
26	Compressor			2000	1,800		20	90	90	1,080	26
27	Booster Heater			2000	1,675		20	84	84	1,007	27
28	Air Conditioner			2000	5,821		20	291	291	3,298	28
29	Air Conditioner			2000	17,320		20	866	866	10,031	29
30	Air Conditioner			2001	3,630		20	182	182	1,938	30
31	Air Conditioner			2001	3,630		20	182	182	1,938	31
32	Air Conditioner			2001	3,111		20	156	156	1,661	32
33	Blinds			2001	1,212		20	61	61	658	33
34	Sprinkler Repair			2001	1,609		20	80	80	870	34
35	Sprinkler Heads			2001	2,145		20	107	107	1,143	35
36	Pipes Repair			2001	1,903		20	95	95	959	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 Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	Dining Room Wall	2002	$ 10,650	$ 191	10	$ 1,065	$ 874	$ 10,295	37
38	Water Heater	2002	4,900		12	408	408	4,049	38
39	Circuit Breaker	2002	1,390		10	139	139	1,367	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	1,717	42
43	Doors	2003	9,995	256	20	500	244	4,499	43
44	Dry Value System	2003	5,623	144	20	281	137	2,413	44
45	Landscaping	2003	8,800	520	20	440	(80)	3,667	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	14,146	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	764	47
48	P.A. Amplifier	2003	713		20	36	36	322	48
49	Security Systems	2004	23,268	846	20	1,163	317	8,725	49
50	16 Transmitters	2004	1,517	55	20	76	21	569	50
51	Nurses Stations	2004	35,000	1,273	20	1,750	477	13,125	51
52	Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	17,525	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	27,930	53
54	Air Conditioners	2005	20,666		7			20,666	54
55	Freezer Door	2005	2,100		20	105	105	683	55
56	Wallpaper	2005	16,140		5			16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	1,802	57
58	Painting and Wallcovering	2005	38,520		5			38,520	58
59	Air Condensors	2005	6,270	228	20	314	86	2,039	59
60	Vinyl Flooring	2005	5,009		5			5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	436	15	467	31	3,034	61
62	Metal Doors	2005	1,926	70	20	96	26	625	62
63	Kitchen Floor	2006	10,300	375	20	515	140	2,833	63
64	Sprinkler System	2006	9,529	346	20	476	130	2,620	64
65	Door Monitors & Paging System	2006	811	29	20	41	12	224	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	1,150	66
67	6 A/C Units	2006	2,576	296	20	129	(167)	709	67
68	6 A/C Units	2006	2,576	297	20	129	(168)	709	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	1,298	69
70	TOTAL (lines 4 thru 69)		$ 5,975,456	$ 12,163		$ 177,851	$ 165,688	$ 1,881,643	70

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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		$ 5,975,456	$ 12,163		$ 177,851	$ 165,688	$ 1,881,643	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	1,018	2
3	Duct Heater	2006	1,349	49	20	67	18	370	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	2,534	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,105	20	2,895	790	13,028	5
6	4 Hot Water Heaters	2007	13,462	490	20	673	183	3,029	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	8,877	7
8	Repair Sprinkler System	2007	3,957	144	20	198	54	891	8
9	Oak flooring	2008	15,571	566	20	779	213	2,726	9
10	Fire alarm system	2008	8,858	322	20	443	121	1,550	10
11	Street and parking lot paving	2008	43,360	1,854	20	2,168	314	7,588	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	826	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	6,913	13
14	Replace pipe and fitting	2009	4,232	154	20	212	58	530	14
15	Air Handling Equipment	2010	22,154	437	20	1,108	671	1,662	15
16	Plumbing Value	2011	4,600	146	20	115	(31)	115	16
17	Hot water system	2011	6,900	178	20	173	(5)	173	17
18	Sprinkler Work	2011	20,035	213	20	918	705	918	18
19	Direct TW system Installation	2011	7,000	74	20	175	101	175	19
20	Handicap shower stall	2011	2,955	22	20	74	52	74	20
21									21
22									22
23									23
24									24
25	Allocation from SW management - leasehold improvements	1995	4,304		20	215	215	3,876	25
26	Allocation from SW management - leasehold improvements	1996	717		20	36	36	558	26
27	Allocation from SW management - leasehold improvements	1997	831		20	42	42	705	27
28	Allocation from SW management - leasehold improvements	1998	710		20	36	36	488	28
29	Allocation from SW management - leasehold improvements	1999	1,972		20	99	99	1,192	29
30	Allocation from SW management - leasehold improvements	2005	4,080		20	204	204	1,326	30
31	Allocation from SW management - leasehold improvements	2007	2,310		20	115	115	520	31
32	Allocation from SW management - leasehold improvements	2009	4,822		20	241	241	603	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,304,117	$ 22,429		$ 193,667	$ 171,238	$ 1,943,907	34

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	$ 997,018	$ 540	$ 9,872	$ 9,332		$ 852,745	71
72	Current Year Purchases	55,162	55,162	2,758	(52,404)		2,758	72
73	Fully Depreciated Assets	152,543					152,543	73
74	Allocated from Mgmt. Co.	12,142		246	246		9,638	74
75	TOTALS	$ 1,216,865	$ 55,702	$ 12,876	$ (42,826)		$ 1,017,684	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	Allocated from Mgmt Co.	Infiniti	2010	$ 6,832	$	$ 1,366	$ 1,366	5	$ 2,050	76
77	2011 Chevy Express van	2011	2011	40,007	11,260	4,001	(7,259)		4,001	77
78										78
79										79
80	TOTALS			$ 46,839	$ 11,260	$ 5,367	$ (5,893)		$ 6,051	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)	$ 7,917,821	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 89,391	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 211,910	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 122,519	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,967,642	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, Inc. # 0039644 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
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 ☐ NO
16. Rental Amount for movable equipment: $ 193 Description: Nursing Equipment
(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.		$	$ 1,105	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,105	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 Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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

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.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	L10A, C3	hrs	$	4,333	$ 311,993	$	4,333	$ 311,993	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,491	119,571		2,491	119,571	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,624	295,963		4,624	295,963	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						149,128	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			$	11,448	$ 727,527	$	11,448	$ 876,655	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.

STATE OF ILLINOIS

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	$ 1,000	$ 131,628	1
2	Cash-Patient Deposits	19,960	19,960	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	2,229,130	2,229,130	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,977	39,504	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,315,111	1,413,908	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,574,178	$ 3,834,130	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		5,303,634	14
15	Leasehold Improvements, at Historical Cost	729,665	1,000,483	15
16	Equipment, at Historical Cost	550,758	1,263,704	16
17	Accumulated Depreciation (book methods)	(777,145)	(2,967,642)	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		173,775	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 503,278	$ 5,123,954	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,077,456	$ 8,958,084	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 248,092	$ 254,992	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,558	29,558	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,412	94,412	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,466	18,466	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,593	32
33	Accrued Interest Payable		30,911	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	511,376	511,376	36
37	See Schedule 17A	162,115	91,663	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,064,019	$ 1,106,971	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,841,416	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)**	$	$ 5,841,416	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,064,019	$ 6,948,387	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,013,437	$ 2,009,697	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,077,456	$ 8,958,084	48

*(See instructions.)

Caseyville Nursing & Rehabilitation Center, Inc. **Sch 17A**
0039644
12/31/2011

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	14,107	14,107
Reimbursement Due		
Short Term Loan Exchange	1,277,994	1,277,994
Due to Public Aid	23,010	23,010
Total Line 9-Other Current Assets (Specify)	1,315,111	1,453,618

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	1,698	1,698
Acc. Retirement (From P/R)	-	-
Accrued Expenses	209,678	209,678
Short Term Loan Exchange	300,000	300,000
Total Line 36-Other Current Liabilities (Specify)	511,376	511,376
Due from State	91,663	91,663
Due/From Caseyville Prop. LLC	70,452	(54,821)
Total Line 37-Other Current Liabilities (Specify)	162,115	36,842

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 **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**	$ 2,184,916	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,184,916	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	828,520	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 828,521	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)**	$ 3,013,437	24 *

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	$ 6,646,651	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,646,651	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	661,632	6
7	Oxygen	8,994	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 670,626	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,909	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,909	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Medicaid Income Adjustment	40,704	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,704	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,378,890	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,292,948	31
32	Health Care	2,797,885	32
33	General Administration	1,432,077	33
	B. Capital Expense		
34	Ownership	705,629	34
	C. Ancillary Expense		
35	Special Cost Centers	239,706	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)***	$ 6,550,370	40
41	**Income before Income Taxes (line 30 minus line 40)****	828,520	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 828,520	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.

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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	1,915	2,110	$ 69,681	$ 33.02	1
2	Assistant Director of Nursing	1,834	2,017	59,407	29.45	2
3	Registered Nurses	1,286	1,301	31,887	24.51	3
4	Licensed Practical Nurses	27,738	29,679	645,478	21.75	4
5	CNAs & Orderlies	85,856	90,522	908,992	10.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,661	9,669	122,960	12.72	8
9	Activity Director					9
10	Activity Assistants	5,687	6,232	78,599	12.61	10
11	Social Service Workers	3,455	3,877	57,412	14.81	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	40,579	19.51	13
14	Head Cook	7,317	8,332	97,918	11.75	14
15	Cook Helpers/Assistants	12,471	13,280	117,637	8.86	15
16	Dishwashers					16
17	Maintenance Workers	6,295	7,176	121,986	17.00	17
18	Housekeepers	14,444	15,566	153,741	9.88	18
19	Laundry	14,022	15,248	131,134	8.60	19
20	Administrator	1,960	2,080	82,035	39.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,586	17,072	420,333	24.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	210,383	226,241	$ 3,139,779 *	$ 13.88	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	Monthly	$ 4,136	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,381	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	8,418	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)		$ 20,735		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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Geralyn Isenberg	Administrator	0	$ 82,035
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,035

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
Helper Broom LLC	Legal	$ 54,572
Stone MacGuire & Siegel	Legal	6,995
Field and Goldberg,LLC	Legal	3,071
Stephen Sher	Legal	4,782
Polsinelli Shughart	Legal	30,468
Unemployement consultant,Inc	U/E Consultant	1,500
McGladrey & Pullen, LLP	Accounting	16,575
Honkamp & Krueger Co.	Accounting	3,561
Personnel Planners, Inc.	U/E Consultant	1,140
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 122,664

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,488
Unemployment Compensation Insurance	86,511
FICA Taxes	237,607
Employee Health Insurance	64,100
Employee Meals	5,382
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	54
Employee Life Insurance	(484)
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,658

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 151)	1,815
Patient Background Checks	
Miscellaneous Inspections & Licenses	625
Miscellaneous Dues & Permits	2,769
Allocated from Management Co.	121
Allocated from RE Entity	501
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,821

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,845
Seminar Expense	
Allocated from Management Co.	23
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,868

**See instructions.

Caseyville Nursing & Rehabilitation Center, Inc.
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	122,664
Disallowed OOP legal	(1,182)
Allocated from Real Estate Entity - Accounting	
- Legal	
- Accounting	6,900
Allocated from Mangement Company	
- Legal	172
- Accounting	1,193
Total (Agree to Schedule V, Line 19, Column 8)	129,747

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 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									N/A				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 **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-$**

(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. $ **712** 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. $ **5,382** 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.