

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0039644

Facility Name: Caseyville Nursing & Rehabilitation Center

Address: 601 West Lincoln Avenue Caseyville 62232
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
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 01/01/2012 to 12/31/2012 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)
	(Type or Print Name)
	(Title)
Paid Preparer	(Signed)
	(Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone)

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# 0039644 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,900</u>	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	<u>150</u>	TOTALS	<u>150</u>	<u>54,900</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>690</u>	<u>1,163</u>	<u>3,654</u>	<u>5,507</u>	8
9	SNF/PED					9
10	ICF	<u>25,635</u>	<u>11,451</u>		<u>37,086</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,325</u>	<u>12,614</u>	<u>3,654</u>	<u>42,593</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.58%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 06/01/94NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 30 and days of care provided 3,654Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	263,076	26,370	6,096	295,542		295,542		295,542			1
2	Food Purchase		272,749		272,749		272,749	(3,181)	269,568			2
3	Housekeeping	165,932	72,037		237,969		237,969	63	238,032			3
4	Laundry	125,841	13,094		138,935		138,935		138,935			4
5	Heat and Other Utilities			156,990	156,990		156,990	1,473	158,463			5
6	Maintenance	55,106	87,871	13,623	156,600		156,600	496	157,096			6
7	Other (specify):*											7
8	TOTAL General Services	609,955	472,121	176,709	1,258,785		1,258,785	(1,149)	1,257,636			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,902,378	80,999	9,233	1,992,610		1,992,610	(3,700)	1,988,910			10
10a	Therapy											10a
11	Activities	77,547	14,194		91,741		91,741		91,741			11
12	Social Services	54,224			54,224		54,224		54,224			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,034,149	95,193	14,033	2,143,375		2,143,375	(3,700)	2,139,675			16
	C. General Administration											
17	Administrative	84,678		316,200	400,878		400,878	(274,541)	126,337			17
18	Directors Fees											18
19	Professional Services			88,972	88,972		88,972	1,380	90,352			19
20	Dues, Fees, Subscriptions & Promotions			34,185	34,185		34,185	685	34,870			20
21	Clerical & General Office Expenses	456,690		51,294	507,984		507,984	51,686	559,670			21
22	Employee Benefits & Payroll Taxes			456,740	456,740		456,740	5,446	462,186			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,195	2,195		2,195	(99)	2,096			24
25	Other Admin. Staff Transportation			28,624	28,624		28,624	2,455	31,079			25
26	Insurance-Prop.Liab.Malpractice			84,939	84,939		84,939	18,734	103,673			26
27	Other (specify):* Mgmt Alloc of Benefi							17,885	17,885			27
28	TOTAL General Administration	541,368		1,063,149	1,604,517		1,604,517	(176,369)	1,428,148			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,185,472	567,314	1,253,891	5,006,677		5,006,677	(181,218)	4,825,459			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			23,151	23,151		23,151	195,356	218,507			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,630	8,630		8,630	186,492	195,122			32
33	Real Estate Taxes							71,739	71,739			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)				34
35	Rent-Equipment & Vehicles							1,061	1,061			35
36	Other (specify):* Mortgage Insurance							33,314	33,314			36
37	TOTAL Ownership			595,781	595,781		595,781	(76,038)	519,743			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,590	860,957	969,547		969,547		969,547			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			318,042	318,042		318,042		318,042			42
43	Other (specify):* Non-Allowable Co			107,017	107,017		107,017	(107,017)				43
44	TOTAL Special Cost Centers		108,590	1,286,016	1,394,606		1,394,606	(107,017)	1,287,589			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,185,472	675,904	3,135,688	6,997,064		6,997,064	(364,273)	6,632,791			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 # 0039644 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,389	30		9
10	Interest and Other Investment Income	(59,169)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(404)	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	(14,690)	43		18
19	Entertainment				19
20	Contributions	(464)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,900)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,272)	43		24
25	Fund Raising, Advertising and Promotional	(125)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(189,267)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (260,902)		\$	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)	(103,371)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (103,371)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (364,273)		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

Page 5A

ID# 0039644
Report Period Beginning: 01/01/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Lab Expense Med A	\$ (7,167)	43	1
2	X Ray Expense Med A	(6,396)	43	2
3	Managed Care Cost	(56,499)	43	3
4	RE Write-Off of Financing Costs	(119,205)	43	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	(189,267)		49

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.

☒ 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	6	Maintenance	\$ 63,732	Caseyville Property LLC	100.00%	\$ 63,732	\$	1
2	V	19	Professional Services		Caseyville Property LLC	100.00%	7,150	7,150	2
3	V	20	Dues, Fees, Subs. & Promotions		Caseyville Property LLC	100.00%	250	250	3
4	V	21	Clerical & General Office Exp.	3	Caseyville Property LLC	100.00%	426	423	4
5	V	26	Insurance-Prop.Liab.Malpractice		Caseyville Property LLC	100.00%	18,284	18,284	5
6	V	30	Depreciation		Caseyville Property LLC	100.00%	163,517	163,517	6
7	V	32	Interest	219	Caseyville Property LLC	100.00%	242,605	242,386	7
8	V	32	Amortization		Caseyville Property LLC	100.00%	3,275	3,275	8
9	V	33	Real Estate Taxes		Caseyville Property LLC	100.00%	65,884	65,884	9
10	V	34	Rent	564,000	Caseyville Property LLC	100.00%		(564,000)	10
11	V	36	Mortgage Insurance		Caseyville Property LLC	100.00%	33,314	33,314	11
12	V	43	Write-Off of Financing Costs		Caseyville Property LLC	100.00%	119,205	119,205	12
13	V								13
14	Total			\$ 627,954			\$ 717,642	\$ * 89,688	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	\$	SW Financial Services Company	100.00%	\$ 305	\$ 305	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	63	63	16
17	V	5	Utilities		SW Financial Services Company	100.00%	1,473	1,473	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	496	496	18
19	V	17	Administrative	316,200	SW Financial Services Company	100.00%	41,659	(274,541)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,194	1,194	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	235	235	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	51,263	51,263	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	101	101	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	2,455	2,455	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	450	450	25
26	V	27	Other		SW Financial Services Company	100.00%	17,885	17,885	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	3,450	3,450	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	2,791	2,791	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	1,061	1,061	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			\$ 316,200			\$ 124,881	\$ * (191,319)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	\$ 6,785	S & E Medical Supply Co.	100.00%	\$ 8,745	\$ 1,960	15
16	V	10	Medical Supplies	6,734	S & E Medical Supply Co.	100.00%	3,034	(3,700)	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			\$ 13,519			\$ 11,779	\$ * (1,740)	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:

01/01/2012

Ending:

12/31/2012

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	Shabbona	Supportive Living	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Sheldon Wolfe	23.67	Shabbona Healthcare Center	Shabbona	SW Financial	Skokie	Bookkeeping/	3
4	Ronnie Klein as Trustee	5.00			Services Co.		Management Comp	4
5	Maurice Aaron	4.67	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Michael Klein Revocable Trust	2.00	Oregon Living & Rehabilitation, LLC	Oregon	* SFO Associates	Skokie	Finance Company	6
7	Wanda Bowling	0.67						7
8	Michael A Klein as Custodian	6.67			* This entity only relates to Shabbona Healthcare Center, Franklin Grove Living & Rehab, and Oregon Living & Rehab			8
9	Michael A Klein as Trustee	6.67						9
10	Kenneth Klein	5.00	Beauvais Manor Healthcare and Rehab	St. Louis, MO				10
11	Susan Stern	4.67	Hillside Manor Healthcare and Rehab	St. Louis, MO	Groves Community	Independence, MO	Hospice	11
12	Jonathan B Stern 2001 Trust	1.56	Rancho Manor Healthcare and Rehab	Florissant, MO	Hospice			12
13	Todd A. Stern 2001 Trust	1.56	Rosewood Health & Rehab	Independence, MO	Forest View Senior	Independence, MO	Independent	13
14	Evan M. Stern	1.56	Seasons Care Center	Kansas City, MO	Residences		Living	14
15	Ora Aaron	4.67			White Oak Living	Independence, MO	Residential	15
16	Moshe Herman	0.67			Center		Care	16
17								17
18					Seasons Day Services	Kansas City, MO	Adult Day Care	18
19					Program LLC			19
20								20
21					Cahokia Building LLC	Cahokia	Real Estae	21
22					Caseyville Property LI	Caseyville	Real Estate	22
23					Shabbona Building	Shabbona	Real Estate	23
24					Associates LLC			24
25								25
26					Franklin Grove	Franklin Grove	Real Estate	26
27					Associates			27
28					Oregon Associates	Oregon	Real Estate	28
29								29
30								30

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center# 0039644Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	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 Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	6	13.33	Salary	\$ 27,880	L17, C7	1
2											2
3											3
4											4
5											5
6			Note: Mr. Wolfe works in excess of 40 hours per week.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,880		13

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

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization SW Financial Services Company
Street Address 7434 N. Skokie Blvd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 982-2300
Fax Number (847) 982-2304

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Bed Days Available	609,314	12	\$ 3,388	\$	54,900	\$ 305	1
2	3	Housekeeping	Bed Days Available	609,314	12	696		54,900	63	2
3	5	Utilities	Bed Days Available	609,314	12	16,350		54,900	1,473	3
4	6	Maintenance	Bed Days Available	609,314	12	5,506		54,900	496	4
5	19	Professional Services-Legal	Bed Days Available	609,314	12	1,572		54,900	142	5
6	19	Professional Services-Other	Bed Days Available	609,314	12	11,672		54,900	1,052	6
7	20	Dues, Fees, Subs. & Promotions	Bed Days Available	609,314	12	2,612		54,900	235	7
8	21	Clerical & General Office Expens	Bed Days Available	609,314	12	495,892	495,892	54,900	44,681	8
9	21	Clerical & General Office Expens	Bed Days Available	609,314	12	73,053		54,900	6,582	9
10	24	Travel & Seminar	Bed Days Available	609,314	12	1,122		54,900	101	10
11	25	Other Admin. Staff Transportation	Bed Days Available	609,314	12	27,251		54,900	2,455	11
12	26	Insurance-Prop, Liab & Malprac	Bed Days Available	609,314	12	4,999		54,900	450	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	609,314	12	198,498		54,900	17,885	13
14	33	Real Estate Taxes	Bed Days Available	609,314	12	30,980		54,900	2,791	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	609,314	12	11,776		54,900	1,061	15
16										16
17	17	Administrative - Salary	Average Hours Worked	45	11	209,100	209,100	6	27,880	17
18	17	Administrative - Salary	Average Hours Worked	45	11	103,345	103,345	6	13,779	18
19										19
20	30	Depreciation	Direct Cost	38,287					3,450	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,197,812	\$ 808,337		\$ 124,881	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization 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			\$	\$		8,745	1
2	10	Medical Supplies	Direct Cost						3,034	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					\$	\$		11,779	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4	5	6		7	8		9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related Long-Term														
1	Heartland Bank		X	Mortgage	\$38,896.00	11/27/01	\$ 6,814,000	\$ 6,155,143	12/1/36	0.0635	\$ 242,605	1			
2												2			
3								Amortization of Mortgage Costs			3,275	3			
4												4			
5												5			
	Working Capital														
6	MB Financial		X	Line of Credit	Demand	1/31/12	1,150,000		1/15/13	0.0425	8,630	6			
7												7			
8												8			
9	TOTAL Facility Related				\$38,896.00		\$ 7,964,000	\$ 6,155,143			\$ 254,510	9			
	B. Non-Facility Related*														
10												10			
11							Interest income offset from Nursing Home				(59,169)	11			
12							Interest income offset from Real Estate Entity				(219)	12			
13												13			
14	TOTAL Non-Facility Related						\$	\$			\$ (59,388)	14			
15	TOTALS (line 9+line14)						\$ 7,964,000	\$ 6,155,143			\$ 195,122	15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 33,314 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.)

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

B. Real Estate Taxes

[illegible]

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Caseyville Nursing & Rehabilitation Center

COUNTY
St. Clair

FACILITY IDPH LICENSE NUMBER
0039644

CONTACT PERSON REGARDING THIS REPORT
Sheldon Wolfe

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 03-07.0-300-005	Long Term Care Property	\$ 69,693.28	\$ 69,693.28
2. 10-28-412-049-0000	SW Financial Services Co. Allocation	\$ 33,685.36	\$ 2,791.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 103,378.64	\$ 72,484.28

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

A. Square Feet: 38,932

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories One

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	\$ 1,619,558	4
5											5
6											6
7	Allocated from Management Co.		1995		35,867		39	1,025	1,025	18,093	7
8											8
	Improvement Type**										
9	Various		1994		22,304	58	20	1,115	1,057	20,330	9
10	Various		1995		52,604	107	20	2,630	2,523	46,071	10
11	Various		1996		2,492		20	125	125	2,184	11
12	Various		1997		11,349	43	20	567	524	8,797	12
13	Various		1998		14,511	227	20	726	499	11,376	13
14	Various		1999		83,394	613	20	4,170	3,557	56,359	14
15	Parking Lot		2000		2,830	167	20	142	(25)	1,748	15
16	Sprinkler System		2000		3,385	87	20	169	82	2,143	16
17	Sprinkler System		2000		5,820	149	20	291	142	3,710	17
18	A/C Repairs		2000		1,018		10			1,018	18
19	Ac Repairs		2000		1,102		20	55	55	693	19
20	Draperies		2000		1,052		20	53	53	646	20
21	Carpeting		2000		1,578		20	79	79	1,001	21
22	Air Handler		2000		1,786		20	89	89	1,116	22
23	Air Conditioner		2000		1,963		7			1,324	23
24	Air Handler		2000		1,241		20	62	62	775	24
25	Air Conditioner		2000		1,029		20	51	51	649	25
26	Compressor		2000		1,800		20	90	90	1,170	26
27	Booster Heater		2000		1,675		20	84	84	1,091	27
28	Air Conditioner		2000		5,821		20	291	291	3,589	28
29	Air Conditioner		2000		17,320		20	866	866	10,897	29
30	Air Conditioner		2001		3,630		20	182	182	2,120	30
31	Air Conditioner		2001		3,630		20	182	182	2,120	31
32	Air Conditioner		2001		3,111		20	156	156	1,817	32
33	Blinds		2001		1,212		20	61	61	719	33
34	Sprinkler Repair		2001		1,609		20	80	80	950	34
35	Sprinkler Heads		2001		2,145		20	107	107	1,250	35
36	Pipes Repair		2001		1,903		20	95	95	1,054	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

0039644

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	\$ 355	\$ 164	\$ 10,650	37
38	Water Heater	2002	4,900		12	408	408	4,457	38
39	Circuit Breaker	2002	1,390		10	23	23	1,390	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	1,904	42
43	Doors	2003	9,995	256	20	500	244	4,999	43
44	Dry Value System	2003	5,623	144	20	281	137	2,694	44
45	Landscaping	2003	8,800	520	20	440	(80)	4,107	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	15,896	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	849	47
48	P.A. Amplifier	2003	713		20	36	36	358	48
49	Security Systems	2004	23,268	846	20	1,163	317	9,888	49
50	16 Transmitters	2004	1,517	55	20	76	21	645	50
51	Nurses Stations	2004	35,000	1,273	20	1,750	477	14,875	51
52	Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	19,862	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	32,227	53
54	Air Conditioners	2005	20,666		7			20,666	54
55	Freezer Door	2005	2,100		20	105	105	788	55
56	Wallpaper	2005	16,140		5			16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	2,079	57
58	Painting and Wallcovering	2005	38,520		5			38,520	58
59	Air Condensers	2005	6,270	228	20	314	86	2,353	59
60	Vinyl Flooring	2005	5,009	182	5		(182)	5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	413	15	467	54	3,501	61
62	Metal Doors	2005	1,926	70	20	96	26	721	62
63	Kitchen Floor	2006	10,300	375	20	515	140	3,348	63
64	Sprinkler System	2006	9,529	346	20	476	130	3,096	64
65	Door Monitors & Paging System	2006	811	29	20	41	12	265	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	1,359	66
67	6 A/C Units	2006	2,576		20	129	129	838	67
68	6 A/C Units	2006	2,576		20	129	129	838	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	1,534	69
70	TOTAL (lines 4 thru 69)		\$ 5,972,869	\$ 11,729		\$ 176,951	\$ 165,222	\$ 2,057,363	70

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

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		\$ 5,972,869	\$ 11,729		\$ 176,951	\$ 165,222	\$ 2,057,363	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	1,203	2
3	Duct Heater	2006	1,349	49	20	67	18	437	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	2,995	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,105	20	2,895	790	15,923	5
6	4 Hot Water Heaters	2007	13,462	490	20	673	183	3,702	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	10,850	7
8	Repair Sprinkler System	2007	3,957	144	20	198	54	1,089	8
9	Oak flooring	2008	15,571	566	20	779	213	3,505	9
10	Fire alarm system	2008	8,858	322	20	443	121	1,993	10
11	Street and parking lot paving	2008	43,360	1,501	20	2,168	667	9,756	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	1,062	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	8,888	13
14	Replace pipe and fitting	2009	4,232	154	20	212	58	742	14
15	Air Handling Equipment	2010	22,154	806	20	1,108	302	2,770	15
16	Plumbing Value	2011	4,600	167	20	230	63	345	16
17	Hot water system	2011	6,900	251	20	345	94	518	17
18	Sprinkler Work	2011	20,035	729	20	1,002	273	1,920	18
19	Direct TV system Installation	2011	7,000		20	350	350	525	19
20	Handicap shower stall	2011	2,955	107	20	148	41	222	20
21									21
22	71 Gallon Hot Water Heater: Nurse Station Mechanical Room	2012	3,389	118	20	85	(33)	85	22
23	100 Gallon Hot Water Heater: Dietary/Maint. Electrical Room	2012	4,917	97	20	123	26	123	23
24	Lighting - Electrical Work: All Resident Rooms	2012	9,975	197	20	249	52	249	24
25	Fire Alarm: Whole Facility	2012	6,434	107	20	161	54	161	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,306,499	\$ 23,151		\$ 193,017	\$ 169,866	\$ 2,126,426	34

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

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 12B, Carried Forward		\$ 6,306,499	\$ 23,151		\$ 193,017	\$ 169,866	\$ 2,126,426	1
2	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	4,014		20	201	201	3,816	2
3	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	668		20	33	33	554	3
4	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	775		20	39	39	696	4
5	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	663		20	33	33	489	5
6	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,840		20	92	92	1,203	6
7	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	3,806		20	190	190	1,427	7
8	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	2,155		20	108	108	592	8
9	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	4,497		20	225	225	788	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	TOTAL (lines 1 thru 33)		\$ 6,324,917	\$ 23,151		\$ 193,938	\$ 170,787	\$ 2,135,991	34

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

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	\$983,543	\$	\$15,064	\$15,064	10	\$857,092	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	166,018					166,018	73
74	Allocated from Management Co.	11,325		230	230	10	9,219	74
75	TOTALS	\$1,160,886	\$	\$15,294	\$15,294		\$1,032,329	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 Management	2010 Infiniti	2010	\$6,372	\$	\$1,274	\$1,274	5	\$3,186	76
77	2011 Chevy Express van	2011	2011	40,007		8,001	8,001		12,002	77
78										78
79										79
80	TOTALS			\$46,379	\$	\$9,275	\$9,275		\$15,188	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)	\$7,882,182	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$23,151	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$218,507	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$195,356	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,183,508	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ N/A
- Description:
-
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Management Co.		\$	\$ 1,061	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,061	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12.
- /2013
- \$
13.
- /2014
- \$
14.
- /2015
- \$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

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	L39, C3	hrs	\$	5,457	\$ 392,902	\$	5,457	\$ 392,902	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,339	112,267		2,339	112,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		5,559	355,788		5,559	355,788	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				108,590		108,590	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			\$	13,355	\$ 860,957	\$ 108,590	13,355	\$ 969,547	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.

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	\$ 98,399	1
2	Cash-Patient Deposits	31,277	31,277	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	2,695,833	2,695,833	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,004	78,196	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,490,338	2,166,558	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,291,452	\$ 5,070,263	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		5,301,046	14
15	Leasehold Improvements, at Historical Cost	754,380	1,023,871	15
16	Equipment, at Historical Cost	550,758	1,207,265	16
17	Accumulated Depreciation (book methods)	(835,969)	(3,183,508)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) See Schedule 17A		86,037	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 469,169	\$ 4,784,711	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,760,621	\$ 9,854,974	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 321,377	\$ 328,402	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,321	32,321	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,587	107,587	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,049	21,049	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,784	32
33	Accrued Interest Payable		18,927	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	456,866	456,866	36
37	See Schedule 17A	26,887	92,325	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 966,087	\$ 1,129,261	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,155,143	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)	\$	\$ 6,155,143	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 966,087	\$ 7,284,404	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,794,534	\$ 2,570,570	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,760,621	\$ 9,854,974	48

*(See instructions.)

XV. BALANCE SHEET -

Other Current Assets (Specify) :	After	
	Operating	Consolidation
RE Replacement Reserve	-	297,149
RE Escrow-Real Estate Tax	-	38,289
Due from State - Interest	59,668	59,668
RE Escrow-Litigation	-	340,782
Employee Payroll Advance	604	604
Short Term Loan Exchange	1,415,902	1,415,902
Due to Public Aid	14,164	14,164
Total Line 9-Other Current Assets (Specify)	1,490,338	2,166,558

Other Long-Term Assets (Specify)

Capitalized Costs	-	89,312
Accululated Amortization	-	(3,275)
Total Line 22-Other Long-Term Assets (specify)	-	86,037

Other Current Liabilities (Specify)

Due from State	91,663	91,663
RE Due to Lessor - Related Party	-	65,438
Reimbursement Due	662	662
Due/From Caseyville Prop. LLC	(65,438)	(65,438)

Total Line 37-Other Current Liabilities (Specify)	26,887	92,325
---	--------	--------

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,013,437	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(35,673)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,977,764	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	816,773	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	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 816,770	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)	\$ 3,794,534	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center# 0039644Report Period Beginning: 01/01/2012Ending: 12/31/2012**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,807,764	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,807,764	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	890,997	6
7	Oxygen	16,840	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 907,837	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***	59,169	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59,169	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Dentist	176	28
28a	Medicaid Income Adjustment	38,891	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 39,067	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,813,837	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,258,785	31
32	Health Care	2,143,375	32
33	General Administration	1,604,517	33
	B. Capital Expense		
34	Ownership	595,781	34
	C. Ancillary Expense		
35	Special Cost Centers	1,076,564	35
36	Provider Participation Fee	318,042	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,997,064	40
41	Income before Income Taxes (line 30 minus line 40)**	816,773	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 816,773	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,008,220	44
45	Private Pay - Net Inpatient Revenue	1,097,784	45
46	Medicare - Net Inpatient Revenue	1,591,720	46
47	Other-(specify) <u>HOSPICE</u>	110,040	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,807,764	49

* 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.

*** 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.

^ - This entity is a cash basis taxpayer.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,005	2,111	\$ 68,832	\$ 32.61	1
2	Assistant Director of Nursing	1,732	1,910	54,137	28.34	2
3	Registered Nurses	2,781	2,859	72,866	25.49	3
4	Licensed Practical Nurses	25,820	27,746	607,427	21.89	4
5	CNAs & Orderlies	84,965	90,083	968,243	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,678	9,489	130,873	13.79	8
9	Activity Director					9
10	Activity Assistants	5,497	6,007	77,547	12.91	10
11	Social Service Workers	3,761	3,960	54,224	13.69	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,152	43,479	20.20	13
14	Head Cook	6,573	7,497	92,793	12.38	14
15	Cook Helpers/Assistants	13,167	14,260	126,804	8.89	15
16	Dishwashers					16
17	Maintenance Workers	3,602	3,926	55,106	14.04	17
18	Housekeepers	14,504	15,694	165,932	10.57	18
19	Laundry	13,377	14,460	125,841	8.70	19
20	Administrator	2,080	2,080	84,678	40.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,122	4,504	104,583	23.22	23
24	Clerical	13,714	15,280	352,107	23.04	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)	208,266	224,018	\$ 3,185,472 *	\$ 14.22	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,096	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	9,233	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				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)		\$ 20,129		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/2012

Page 21

Ending:

12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Geralyn Isenberg	Administrator	0	\$ 84,678	Workers' Compensation Insurance	\$ 54,318	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	104,706	Advertising: Employee Recruitment		
				FICA Taxes	237,437	Health Care Worker Background Check	2,334	
				Employee Health Insurance	59,931	(Indicate # of checks performed 195)		
				Employee Meals	5,446	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Inspections & Licenses	580	
				Employee Life Insurance	348	Miscellaneous Dues & Permits	631	
						Illinois Council on Long Term Care	28,650	
						INHAA Membership	200	
						See Schedule 21F	485	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description				Amount				
SW Financial Services Co.-Home Office				\$ 196,200				
Management Fees				120,000				
(Eliminated on Schedule V, Column 7)								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 316,200				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
Helper Broom LLC	Legal		\$ 44,026				Out-of-State Travel	
Polsinelli Shughart	Legal		15,121	N/A				
Field and Goldberg,LLC	Legal		3,535					
Allen Lefkowitz	Legal		3,064				In-State Travel	
Unemployment Consultants, Inc.	U/E Consultant		3,100					
HK Payroll Services Co.	Accounting		627					
McGladrey LLP	Accounting		17,549					
Honkamp Krueger & Co.	Accounting		1,950				Seminar Expense	
							Allocated from Management Co.	
							101	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 88,972			Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 2,096	

* Attach copy of IMRF notifications

**See instructions.

Caseyville Nursing & Rehabilitation Center, Inc.
0039644
12/31/2012

Schedule 21C

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	88,972
Disallowed OOP legal	(3,900)
Reclass Allen A Lefkovitz & Assoc. to RE Tax Appeal	(3,064)
Allocated from Real Estate Entity - Accounting	7,150
Allocated from Mangement Company	
- Legal	142
- Accounting	1,052
Total (Agree to Schedule V, Line 19, Column 8)	<u>90,352</u>

Schedule 21F

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

Allocated from Management Co.	235
Allocated from RE Entity	<u>250</u>
	<u>485</u>

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care-\$28,650
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 318,042
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. \$ 5,446 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.