

		FOR OHF USE					

LL1

**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

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 Facility ID Number:** 0039644

**Facility Name:** CASEYVILLE NURSING AND REHAB. CENTER

**Address:** 601 WEST LINCOLN CASEYVILLE 62232  
 Number City Zip Code

**County:** ST. CLAIRE

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

**IDPA ID Number:** 36-3952446001

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
 Name: Steve N. Lavenda Telephone Number: (847) 236-1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u>	(Date) _____
	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>	
	(Firm Name & Address) <u>FROST, RUTTENBERG &amp; ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: OFFICE OF HEALTH FINANCE  
 ILLINOIS DEPARTMENT OF PUBLIC AID  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	5,344	1,170	2,477	8,991	8
9	SNF/PED					9
10	ICF	28,897	6,561		35,458	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,241	7,731	2,477	44,449	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.96%

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

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

N/A

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 06/01/94

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 30 and days of care provided 2,477

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/00 Fiscal Year: 12/00

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

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CE # 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	182,781	11,878		194,659		194,659	(1,260)	193,399		1
2	Food Purchase		185,209		185,209		185,209	(322)	184,887		2
3	Housekeeping	109,789	65,554		175,343		175,343		175,343		3
4	Laundry	64,448	28,164		92,612		92,612	(121)	92,491		4
5	Heat and Other Utilities			119,112	119,112		119,112	1,381	120,493		5
6	Maintenance	40,780		58,291	99,071		99,071	(2,327)	96,744		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	397,798	290,805	177,403	866,006		866,006	(2,649)	863,357		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,123,768	16,015	1,177	1,140,960		1,140,960		1,140,960		10
10a	Therapy	59,702		6,796	66,498		66,498		66,498		10a
11	Activities	51,189	5,095	626	56,910		56,910		56,910		11
12	Social Services	36,062			36,062		36,062		36,062		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,270,721	21,110	8,599	1,300,430		1,300,430		1,300,430		16
	<b>C. General Administration</b>										
17	Administrative	139,299		120,000	259,299		259,299	(55,005)	204,294		17
18	Directors Fees										18
19	Professional Services			140,466	140,466		140,466	(106,200)	34,266		19
20	Dues, Fees, Subscriptions & Promotions			28,305	28,305		28,305	(8,219)	20,086		20
21	Clerical & General Office Expenses	136,417	3,691	53,374	193,482		193,482	34,027	227,509		21
22	Employee Benefits & Payroll Taxes			278,393	278,393		278,393	(3,916)	274,477		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,445	2,445		2,445	217	2,662		24
25	Other Admin. Staff Transportation			13,273	13,273		13,273	2,203	15,476		25
26	Insurance-Prop.Liab.Malpractice			76,592	76,592		76,592	30	76,622		26
27	Other (specify):*							11,278	11,278		27
28	<b>TOTAL General Administration</b>	275,716	3,691	712,848	992,255		992,255	(125,585)	866,670		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,944,235	315,606	898,850	3,158,691		3,158,691	(128,234)	3,030,457		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.

CASEYVILLE NURSING AND REHAB. CENTER

0039644

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V  
LINE #

22 EMPLOYEE BENEFITS \_\_\_\_\_

2 FOOD \_\_\_\_\_

To reclass cost of employee meals from raw food to employee benefits

33 REAL ESTATE TAX \_\_\_\_\_

19 PROFESSIONAL FEES \_\_\_\_\_

To reclass cost of appealing real estate taxes

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER #0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			49,007	49,007		49,007	(21,933)	27,074			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,602	73,602		73,602	(30,703)	42,899			32
33	Real Estate Taxes			61,333	61,333		61,333	2,864	64,197			33
34	Rent-Facility & Grounds			623,528	623,528		623,528		623,528			34
35	Rent-Equipment & Vehicles			8,103	8,103		8,103		8,103			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			815,573	815,573		815,573	(49,772)	765,801			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,523	157,109	162,632		162,632	(1,129)	161,503			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		5,523	239,459	244,982		244,982	(1,129)	243,853			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,944,235	321,129	1,953,882	4,219,246		4,219,246	(179,135)	4,040,111			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	(25,079)	30		9
10	Interest and Other Investment Income	(7,275)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(322)	2		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	(15,829)	21		18
19	Entertainment				19
20	Contributions	(2,674)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,220)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(94,152)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (150,551)		\$	30

<b>OHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(28,584)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (28,584)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (179,135)		37

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

ID# 0039644

Report Period Beginning: 01/01/00  
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$ 6	6 1
2	PRIOR YEAR LEGAL FEES	(7,033)	19 2
3	WAGES RELATED TO ANOTHER FACILITY	(52,761)	17 3
4	TRUST FEES	(250)	20 4
5	IL COUNCIL POLITICAL CONTRIBUTIONS	(193)	20 5
6	INTEREST EXPENSE: N/P TO STOCKHOLDERS	(26,072)	32 6
7	MISC. INCOME	(121)	4 7
8	RECLASS A/C REPAIR TO LIMP	(1,018)	6 8
9	RECLASS STEAM VALVE TO EQUIP	(1,130)	6 9
10	RECLASS A/C REPAIR TO LIMP	(1,102)	6 10
11	LEGAL FEES RELATED TO PURCH OF FACILITY	(556)	19 11
12	FICA RELATED TO ANOTHER FACILITY	(3,150)	22 12
13	MEDICARE RELATED TO ANOTHER FACILITY	(766)	22 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			49
50			50
51			51
52			52
53			53
54			54
55			55
56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	<b>Total</b>	(94,152)	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary				(1,260)								(1,260)	1
2	Food Purchase	(322)											(322)	2
3	Housekeeping													3
4	Laundry	(121)											(121)	4
5	Heat and Other Utilities			1,381									1,381	5
6	Maintenance	(3,250)		923									(2,327)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(3,693)</b>		<b>2,304</b>	<b>(1,260)</b>								<b>(2,649)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(52,761)		(2,244)									(55,005)	17
18	Directors Fees													18
19	Professional Services	(7,589)		(98,611)									(106,200)	19
20	Fees, Subscriptions & Promotions	(8,337)		118									(8,219)	20
21	Clerical & General Office Expenses	(15,829)		49,856									34,027	21
22	Employee Benefits & Payroll Taxes	(3,916)											(3,916)	22
23	Inservice Training & Education													23
24	Travel and Seminar			217									217	24
25	Other Admin. Staff Transportation			2,203									2,203	25
26	Insurance-Prop.Liab.Malpractice			30									30	26
27	Other (specify):*			11,278									11,278	27
28	<b>TOTAL General Administration</b>	<b>(88,432)</b>		<b>(37,153)</b>									<b>(125,585)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(92,125)</b>		<b>(34,849)</b>	<b>(1,260)</b>								<b>(128,234)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER # 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(25,079)		3,146									(21,933)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(33,347)		2,644									(30,703)	32
33	Real Estate Taxes			2,864									2,864	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(58,426)</b>		<b>8,654</b>									<b>(49,772)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(1,129)								(1,129)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>				<b>(1,129)</b>								<b>(1,129)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(150,551)</b>		<b>(26,195)</b>	<b>(2,389)</b>								<b>(179,135)</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED				

**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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	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	5 UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 1,381	\$ 1,381	15
16	V	6 REPAIRS AND MAINT.		S.W. MANAGEMENT	100.00%	923	923	16
17	V	19 PROFESSIONAL FEES		S.W. MANAGEMENT	100.00%	3,389	3,389	17
18	V	20 FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT	100.00%	118	118	18
19	V	21 CLERICAL AND GENERAL		S.W. MANAGEMENT	100.00%	49,856	49,856	19
20	V	24 EDUCATION AND SEMINARS		S.W. MANAGEMENT	100.00%	217	217	20
21	V	25 TRANSPORTATION		S.W. MANAGEMENT	100.00%	2,203	2,203	21
22	V	26 INSURANCE - PROPERTY		S.W. MANAGEMENT	100.00%	30	30	22
23	V	27 PAYROLL TAXES		S.W. MANAGEMENT	100.00%	8,800	8,800	23
24	V	30 DEPRECIATION		S.W. MANAGEMENT	100.00%	3,146	3,146	24
25	V	32 INTEREST EXPENSE		S.W. MANAGEMENT	100.00%	2,644	2,644	25
26	V	33 REAL ESTATE TAXES		S.W. MANAGEMENT	100.00%	2,864	2,864	26
27	V	0		S.W. MANAGEMENT				27
28	V	0		S.W. MANAGEMENT				28
29	V	0		S.W. MANAGEMENT				29
30	V	17 SALARY - SHELDON WOLFE		S.W. MANAGEMENT	100.00%	52,756	52,756	30
31	V	17 SALARY - RONNIE KLEIN		S.W. MANAGEMENT	100.00%	5,000	5,000	31
32	V	27 EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT	100.00%	1,541	1,541	32
33	V	27 EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT	100.00%	937	937	33
34	V	0		S.W. MANAGEMENT				34
35	V	19 HOME OFFICE/MGMNT. FEES	102,000	S.W. MANAGEMENT	100.00%		(102,000)	35
36	V	17 MANAGEMENT FEES	60,000				(60,000)	36
37	V							37
38	V							38
39	Total		\$ 162,000			\$ 135,805	\$ * (26,195)	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	1 Dietary Supplements	13,858	S & E	100.00%	12,598	\$ (1,260)	15
16	V	39 Medicare A Supplements	6,776	S & E	100.00%	5,647	(1,129)	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		\$ 20,634			\$ 18,245	\$ * (2,389)	39

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

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. C] # 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

## 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 Attached	5	12.00	Sal-SW MGT	\$ 52,756	17-7	1
2	Ronnie Klein	Shareholder	Administrative	5.00	See Attached	5	12.00	Sal-SW MGT	5,000	17-7	2
3								Mgmt Fees	60,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 117,756		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 AND REHAB. CENTER # 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_\_) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER # 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

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.W. MANAGEMENT  
 Street Address 7434 N. SKOKIE BLVD.  
 City / State / Zip Code SKOKIE, IL. 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	H. O. / MGMT. FEE INC. 1,673,600	10	\$ 14,270	\$	162,000	\$ 1,381	1
2	6	REPAIRS AND MAINT.	H. O. / MGMT. FEE INC. 1,673,600	10	9,537		162,000	923	2
3	19	PROFESSIONAL FEES	H. O. / MGMT. FEE INC. 1,673,600	10	35,007		162,000	3,389	3
4	20	FEES, SUBSCRIPTIONS, DUES	H. O. / MGMT. FEE INC. 1,673,600	10	1,218		162,000	118	4
5	21	CLERICAL AND GENERAL	H. O. / MGMT. FEE INC. 1,673,600	10	515,053	446,676	162,000	49,856	5
6	24	EDUCATION AND SEMINARS	H. O. / MGMT. FEE INC. 1,673,600	10	2,244		162,000	217	6
7	25	TRANSPORTATION	H. O. / MGMT. FEE INC. 1,673,600	10	22,760		162,000	2,203	7
8	26	INSURANCE - PROPERTY	H. O. / MGMT. FEE INC. 1,673,600	10	309		162,000	30	8
9	27	PAYROLL TAXES	H. O. / MGMT. FEE INC. 1,673,600	10	90,916		162,000	8,800	9
10	30	DEPRECIATION	H. O. / MGMT. FEE INC. 1,673,600	10	32,499		162,000	3,146	10
11	32	INTEREST EXPENSE	H. O. / MGMT. FEE INC. 1,673,600	10	27,315		162,000	2,644	11
12	33	REAL ESTATE TAXES	H. O. / MGMT. FEE INC. 1,673,600	10	29,591		162,000	2,864	12
13									13
14									14
15									15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED 60	10	633,071	633,071	5	52,756	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED 60	7	60,000	60,000	5	5,000	17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED 60	10	18,497		5	1,541	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED 60	7	11,246		5	937	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,503,533	\$ 1,139,747		\$ 135,805	25

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER # 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplements	Direct Allocation		\$	\$		\$ 12,598	1
2	39	Medicare A Supplements	Direct Allocation					5,647	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				\$	\$		\$ 18,245	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	<b>KENWOOD</b>	<b>X</b>		<b>WORKING CAPITAL</b>			<b>765,910</b>		<b>8.00%</b>	<b>47,530</b>	6									
7	<b>N/P STPCKHOLDERS</b>	<b>X</b>		<b>WORKING CAPITAL</b>			<b>214,330</b>		<b>PRIME+1</b>	<b>26,072</b>	7									
8											8									
9	<b>TOTAL Facility Related</b>					\$	\$ <b>980,240</b>			\$ <b>73,602</b>	9									
<b>B. Non-Facility Related*</b>																				
10	<b>Supplemental Schedule</b>									<b>(30,703)</b>	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ <b>(30,703)</b>	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$ <b>980,240</b>			\$ <b>42,899</b>	15									

\* 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 AND REHAB. CEN

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

**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			
1	ALLOC. FROM SW MANG.	X		HOME OFFICE ALLOC			\$	\$			\$	2,644	1							
2	INTEREST INCOME		X									(7,275)	2							
3	INT. TO STOCKHOLDERS	X										(26,072)	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							\$	\$			\$	(30,703)	21							

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>69,880</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>66,871</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(3,009)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>67,207</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>64,198</b>	<b>7</b>
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<b>90,055</b>	<b>8</b>
	1996	<b>74,261</b>	<b>9</b>
	1997	<b>64,690</b>	<b>10</b>
	1998	<b>66,553</b>	<b>11</b>
	1999	<b>64,007</b>	<b>12</b>
<b>SW MANAGEMENT REAL ESTATE TAX ALLOCATION = \$2,864</b>			
<b>2000 REAL ESTATE TAX ACCRUAL = \$64,007*1.05=67,207</b>			
<b>REAL ESTATE TAX PAID = \$66,407 + \$2,864</b>			
<b>FOR OFF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	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.**

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644 Report Period Beginning:

01/01/00 Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories ONE

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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, nurse aide 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

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Land. Row 2: 1. Row 3: 2. Row 4: 3 TOTALS

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1994	22,302	1,785	20	1,115	(670)	6,964	9
10	Various		1995	52,604	3,128	20	2,631	(497)	14,506	10
11	COIL DUCTWORK		1996	2,492	287	20	125	(162)	687	11
12	AIR CONDITIONER		1997	1,100		20	55	55	202	12
13	WALK IN COOLER		1997	3,200		20	160	160	533	13
14	250000 BTU GAS HEATE		1997	3,890		20	195	195	715	14
15	AIR CONDITIONER		1997	1,475		20	74	74	265	15
16	SOUND ABSORBANT CEIL		1997	1,684	43	20	84	41	273	16
17	WATER HEATE		1998	3,775	660	20	189	(471)	630	17
18	CARPET		1998	1,866	326	20	187	(139)	499	18
19	GARAGE		1998	8,870	227	20	444	217	1,258	19
20	ROOF (NET COST)		1999	23,890	613	20	1,195	582	1,494	20
21	AIR CONDITIONER		1999	2,152	688	20	108	(580)	198	21
22	FIRE PROTECTION		1999	2,239	716	20	112	(604)	187	22
23	COMPRESSOR		1999	1,750	560	20	88	(472)	154	23
24										24
25	<b>PAGE 12-1 REP TOTALS</b>			<b>52,860</b>	<b>1,583</b>		<b>1,680</b>	<b>97</b>	<b>7,374</b>	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35	<b>PAGE 12A TOTALS</b>			<b>102,783</b>	<b>24,431</b>		<b>4,104</b>	<b>(20,327)</b>	<b>5,719</b>	35
36	<b>TOTAL (lines 4 thru 35)</b>			<b>\$ 288,932</b>	<b>\$ 35,047</b>		<b>\$ 12,546</b>	<b>\$ (22,501)</b>	<b>\$ 41,658</b>	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.

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Bed* <sup>s</sup>	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>FIRE PROTECTION</b>	1999		2,107	674	20	105	(569)	210	9
10		<b>FIRE PROTECTION</b>	1999		4,235	1,355	20	212	(1,143)	424	10
11		<b>WATER HEATER</b>	1999		3,970	1,270	20	199	(1,071)	315	11
12		<b>AIR CONDITIONER</b>	1999		1,434	459	20	72	(387)	108	12
13		<b>WATER HEATER</b>	1999		4,300	1,376	20	215	(1,161)	340	13
14		<b>HORIZONTAL BLINDS</b>	1999		6,739	2,156	20	337	(1,819)	449	14
15		<b>AIR CONDITIONER</b>	1999		1,503	481	20	75	(406)	106	15
16		<b>FIRE PROTECTION</b>	1999		2,740	877	20	137	(740)	263	16
17		<b>FIRE PROTECTION</b>	1999		1,810	579	20	91	(488)	152	17
18		<b>FIRE PROTECTION</b>	1999		5,990	1,917	20	300	(1,617)	450	18
19		<b>FIRE PROTECTION</b>	1999		14,800	4,736	20	740	(3,996)	1,110	19
20		<b>FIRE PROTECTION</b>	1999		3,735	1,195	20	187	(1,008)	358	20
21		<b>CARPETING</b>	2000		1,578	316	20	46	(270)	46	21
22		<b>A/C REPAIRS</b>	2000		1,102		20	32	32	32	22
23		<b>PARKING LOT</b>	2000		2,830	142	20	47	(95)	47	23
24		<b>SPRINKLER SYSTEM</b>	2000		3,385	54	20	113	59	113	24
25		<b>SPRINKLER SYSTEM</b>	2000		5,820	106	20	218	112	218	25
26		<b>BOOSTER HEATER</b>	2000		1,675	335	20	84	(251)	84	26
27		<b>AIR CONDITIONER</b>	2000		1,029	206	20	34	(172)	34	27
28		<b>AIR HANDLER</b>	2000		1,241	248	20	26	(222)	26	28
29		<b>AIR CONDITIONER</b>	2000		1,963	393	20	41	(352)	41	29
30		<b>AIR CONDITIONER</b>	2000		5,821	1,164	20	97	(1,067)	97	30
31		<b>AIR CONDITIONER</b>	2000		17,320	3,464	20	505	(2,959)	505	31
32		<b>DRAPERIES</b>	2000		1,052	211	20	13	(198)	13	32
33		<b>A/C REPAIRS</b>	2000		1,018		20	51	51	51	33
34		<b>COMPRESSOR</b>	2000		1,800	360	20	90	(270)	90	34
35		<b>AIR HANDLER</b>	2000		1,786	357	20	37	(320)	37	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 102,783	\$ 24,431		\$ 4,104	\$ (20,327)	\$ 5,719	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.

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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.

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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.

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1995	SW MGMT	\$ 43,562	\$ 1,117	35	\$ 1,245	\$ 128	\$ 5,794	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	ALLOC SW MANAGEMENT		1995	4,470	231	20	267	36	1,182	9
10	ALLOC SW MANAGEMENT		1996	781	20	20	39	19	139	10
11	ALLOC SW MANAGEMENT		1997	1,124	140	20	81	(59)	182	11
12	ALLOC SW MANAGEMENT		1998	774	20	20	39	19	68	12
13	ALLOC SW MANAGEMENT		1999	2,149	55	20	9	(46)	9	13
14	ALLOC SW MANAGEMENT		2000							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	TOTAL (lines 4 thru 35)			\$ 52,860	\$ 1,583		\$ 1,680	\$ 97	\$ 7,374	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.

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 142,761	\$ 14,738	\$ 14,241	\$ (497)		\$ 66,424	37
38	Current Year Purchases	7,376	2,368	287	(2,081)		287	38
39	Fully Depreciated Assets							39
40								40
41	<b>TOTALS</b>	\$ 150,137	\$ 17,106	\$ 14,528	\$ (2,578)		\$ 66,711	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	<b>TOTALS</b>			\$	\$	\$	\$		\$	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 439,069	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 52,153	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 27,074	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (25,079)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 108,369	51

\*\*

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	<b>TOTALS</b>	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

CASEYVILLE NURSING AND REHAB. CENTER  
0039644  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
CASEYVILLE NURSING AND REHAB	134,266	14,572	13,430	(1,142)	61,796
SW MANAGEMENT	8,495	166	811	645	4,628
<b>TOTALS</b>	<b>142,761</b>	<b>14,738</b>	<b>14,241</b>	<b>(497)</b>	<b>66,424</b>

<b>LINE 29: CURRENT YEAR</b>					
CASEYVILLE NURSING AND REHAB	5,979	971	266	(705)	266
SW MANAGEMENT	1,397	1,397	21	(1,376)	21
<b>TOTALS</b>	<b>7,376</b>	<b>2,368</b>	<b>287</b>	<b>(2,081)</b>	<b>287</b>

<b>LINE 30: FULLY DEPRECIATED</b>					
CASEYVILLE NURSING AND REHAB					
SW MANAGEMENT					
<b>TOTALS</b>					

**TOTALS (Should Tie to Totals on Page 13)**

CASEYVILLE NURSING AND REHAB	140,245	15,543	13,696	(1,847)	62,062
SW MANAGEMENT	9,892	1,563	832	(731)	4,649
<b>TOTALS</b>	<b>150,137</b>	<b>17,106</b>	<b>14,528</b>	<b>(2,578)</b>	<b>66,711</b>

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: CASEYVILLE PROPERTIES (UNRELATED TO CASEYVILLE NURSING AND REHAB. CENTER)

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1987</u>	<u>150</u>	<u>06/01/94</u>	\$ <u>623,527</u>	<u>10</u>	<u>20</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>150</u>		\$ <u>623,527</u>			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: SEE ATTACHED SCHEDULE \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>BUSINESS</u>	<u>1999 CHRYSLER 300M</u>	\$ <u>675.28</u>	\$ <u>8,103</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>675.28</u>	\$ <u>8,103</u>	21

10. Effective dates of current rental agreement:

Beginning 06/01/94

Ending 05/31/04

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

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_

13. /2002 \$ \_\_\_\_\_

14. /2003 \$ \_\_\_\_\_

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

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

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 33,532	\$		\$ 33,532	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			24,214			24,214	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			33,982			33,982	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			64,284			64,284	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>**SEE SUPPLEMENTAL SCHEDULE**</b>					1,097	5,523		6,620	13
14	<b>TOTAL</b>			\$		\$ 157,109	\$ 5,523		\$ 162,632	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 nurse aides, who help with the above activities should not be listed on this schedule.**

**SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES**

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	595
2 Complex Medical Equip	
3 Oxygen	69
4 Equipment Rental	
5	
6 ENTERAL	4,859
7	
8	
9	
10	
	<u>5,523</u>

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2 X RAY	1,097
3	
4	
5	
6	
7	
8	
9	
10	
	<u>1,097</u>

Facility Name & ID Number **CASEYVILLE NURSING AND REHAB. CENTER** # **0039644** Report Period Beginning: **01/01/00** Ending: **12/31/00**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **12/31/00** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 177,258	\$	1
2	Cash-Patient Deposits	21,209		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	502,873		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,930		6
7	Other Prepaid Expenses	236		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See supplemental schedule</u>	203,296		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 936,802	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	55,356		15
16	Equipment, at Historical Cost	317,713		16
17	Accumulated Depreciation (book methods)	(241,203)		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):	300,000		22
23	Other(specify): <u>See supplemental schedule</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 431,866	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,368,668	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 169,761	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,685		28
29	Short-Term Notes Payable	980,240		29
30	Accrued Salaries Payable	65,093		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,576		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,207		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See supplemental schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,320,562	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See supplemental schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,320,562	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 48,106	\$ #REF!	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,368,668	\$ #REF!	48

\*(See instructions.)

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	73,233	
Employee Loans	87	
Short Term Loan Exchange	129,976	
	<u>203,296</u>	

OTHER CURRENT LIABILITIES:

	<u>Amount</u>	<u>Amount</u>
Accrued Expenses		

OTHER NON CURRENT ASSETS:

Construction In Progress  
 Utility Deposit  
 Loan Costs


OTHER NON CURRENT LIABILITIES:


**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>983,974</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">Schedule attached</a>	<b>(1,138,066)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(154,092)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>202,198</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>202,198</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>48,106</b>	<b>24</b> *

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

Facility Name & ID Number CASEYVILLE NURSING AND REHA# 0039644 Report Period Beginning: 01/01/00 Ending: 12/31/00

Balance per General Ledger (154,092)

Adjustments:

-  
-  
-

MEDICARE COST ALLOWANCE 1,138,066

Total adjustments 1,138,066

Balance - Beginning of Year 983,974

Equity(Deficit) from Page 17 Col 1 48,106

Related Party  
Equity(Deficit) 0  
Income 0

-

Combined Equity - End of Year 48,106

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,325,136	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,325,136	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	51,510	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 51,510	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	37,290	19
20	Radiology and X-Ray		20
21	Other Medical Services	112	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 37,402	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,396	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,396	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See supplemental schedule</u>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,421,444	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	866,006	31
32	Health Care	1,300,430	32
33	General Administration	992,255	33
<b>B. Capital Expense</b>			
34	Ownership	815,573	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	162,632	35
36	Provider Participation Fee	82,350	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,219,246	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	202,198	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 202,198	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS 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.

SUPPLEMENTAL SCHEDULE OF REVENUES  
12/31/00

DESCRIPTION AMOUNT

1 Vending Commissions

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

TOTALS

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning: 01/01/00

Ending: 12/31/00

12/31/00

**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	2,000	2,080	\$ 49,300	\$ 23.70	1
2	Assistant Director of Nursing	780	796	16,462	20.68	2
3	Registered Nurses	8,354	8,692	156,794	18.04	3
4	Licensed Practical Nurses	19,174	20,456	328,434	16.06	4
5	Nurse Aides & Orderlies	62,927	66,950	572,777	8.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,258	5,859	59,701	10.19	8
9	Activity Director					9
10	Activity Assistants	5,215	5,744	51,189	8.91	10
11	Social Service Workers	3,135	3,447	36,062	10.46	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	22,500	10.82	13
14	Head Cook	5,253	5,763	43,469	7.54	14
15	Cook Helpers/Assistants	14,988	15,781	116,812	7.40	15
16	Dishwashers					16
17	Maintenance Workers	3,375	3,701	40,780	11.02	17
18	Housekeepers	16,151	17,187	109,789	6.39	18
19	Laundry	10,108	10,625	64,449	6.07	19
20	Administrator	2,000	2,080	60,157	28.92	20
21	Assistant Administrator					21
22	Other Administrative	4,215	4,417	79,142	17.92	22
23	Office Manager					23
24	Clerical	10,901	11,779	136,417	11.58	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)	0	0	0		33
34	TOTAL (lines 1 - 33)	175,834	187,437	\$ 1,944,234 *	\$ 10.37	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	42	1,050	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	as needed	6,796	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	as needed	627	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	42	\$ 8,473		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			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

**SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS**

**B. CONSULTANT SERVICES**

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>

**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	
Gerry Isenberg	Administrator	0	\$ 60,157	Workers' Compensation Insurance	\$ 30,211	IDPH License Fee	\$	
Robin Suydam	Administrator	0	79,142	Unemployment Compensation Insurance	34,071	Advertising: Employee Recruitment	3,314	
				FICA Taxes	144,754	Health Care Worker Background Check	514	
				Employee Health Insurance	58,305	(Indicate # of checks performed <u>51</u> )		
				Employee Meals		<b>DUES&amp;SUBSCRIPTIONS</b>	7,196	
				Illinois Municipal Retirement Fund (IMRF)*		<b>ADVERTISING</b>	5,220	
				<b>MISC. EMPLOYEE BENEFITS</b>	7,136	<b>LICENSES AND INSPECTIONS</b>	8,945	
						<b>ALLOC. FROM RELATED PARTY</b>	118	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 139,299			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	(5,220)	
Description			Amount			Yellow page advertising	( )	
SW MANAGEMENT - MANAGEMENT FEES			\$ 60,000					
RONNIE KLEIN - MANAGEMENT FEES			60,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 120,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 274,477	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,087	
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	Amount
			\$ 0			\$	Out-of-State Travel	\$
FR&R	ACCOUNTING		15,997					
PERSONNEL PLANNERS	UNEMPLOY. CONSULTANT		1,237					
SW MANAGEMENT	HOME OFFICE FEES		102,000				In-State Travel	
BLACKWELL, SANDERS, PEPER	LEGAL		5,032					
WINSTON AND STRAWN	LEGAL		13,512					
SACHNOFF AND WEAVER	LEGAL		556					
DAVID E. LEWIS	LEGAL		98				Seminar Expense	2,445
KASSLY, BONE, ENGL.	LEGAL		861				<b>ALLOCATED FROM RELATED PARTY</b>	217
ASHMAN AND STEIN	LEGAL		1,175					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 140,468	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	\$ 2,662

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning:

01/01/00

Ending:

12/31/00

**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 LTC - \$6,638
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES NO 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 82,350  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
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. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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 \$2500, 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

**Date:** 07/17/2000

**To:** Administrator/Cost Report Preparer

**From:** Office of Health Finance

**Re:** 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

**Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

**Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/ov

**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							\$	15	
16	V								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	<b>Total</b>			\$			\$	<b>0</b>	\$ *	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			\$			\$	\$	15	
16	V								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	<b>Total</b>			\$			\$	0	\$ *	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			\$			\$	\$	15	
16	V								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	<b>Total</b>			\$			\$	0	\$ *	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			\$			\$	\$	15	
16	V								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	<b>Total</b>			\$			\$	0	\$ *	39

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

Facility Name & ID Number CASEYVILLE NURSING AND REHAB. CENTER

# 0039644

Report Period Beginning: 01/01/00

Ending: 12/31/00

**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			\$			\$	\$	15	
16	V								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	<b>Total</b>			\$			\$	0	\$ *	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			\$			\$	\$	15	
16	V								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	<b>Total</b>			\$			\$	0	\$ *	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			\$			\$	\$	15	
16	V								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	<b>Total</b>			\$			\$	0	\$ *	39

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