

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	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	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,039	1,242	3,957	7,238	8
9	SNF/PED					9
10	ICF	30,988	4,297		35,285	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,027	5,539	3,957	42,523	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.67%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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 06/01/94 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 3,957

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	238,596	15,980	3,826	258,402		258,402		258,402		1
2	Food Purchase		260,333		260,333		260,333	(8,635)	251,698		2
3	Housekeeping	103,848	57,609		161,457		161,457	250	161,707		3
4	Laundry	142,353	9,665		152,018		152,018		152,018		4
5	Heat and Other Utilities			158,421	158,421		158,421	1,456	159,877		5
6	Maintenance	90,835	81,824	11,287	183,946		183,946	724	184,670		6
7	Other (specify):*										7
8	TOTAL General Services	575,632	425,411	173,534	1,174,577		1,174,577	(6,205)	1,168,372		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	1,728,429	66,600	8,982	1,804,011		1,804,011	1,243	1,805,254		10
10a	Therapy			688,470	688,470		688,470		688,470		10a
11	Activities	73,491	6,679	98	80,268		80,268		80,268		11
12	Social Services	53,614			53,614		53,614		53,614		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,855,534	73,279	701,150	2,629,963		2,629,963	1,243	2,631,206		16
	C. General Administration										
17	Administrative	79,318		181,605	260,923		260,923	(133,805)	127,118		17
18	Directors Fees										18
19	Professional Services			56,707	56,707		56,707	20,197	76,904		19
20	Dues, Fees, Subscriptions & Promotions			23,642	23,642		23,642	385	24,027		20
21	Clerical & General Office Expenses	370,240		30,849	401,089		401,089	40,406	441,495		21
22	Employee Benefits & Payroll Taxes			349,419	349,419		349,419	4,980	354,399		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,410	1,410		1,410	15	1,425		24
25	Other Admin. Staff Transportation			34,635	34,635		34,635	1,224	35,859		25
26	Insurance-Prop.Liab.Malpractice			16,167	16,167		16,167	4,715	20,882		26
27	Other (specify):* Mgmt Alloc of Benefit							15,231	15,231		27
28	TOTAL General Administration	449,558		694,434	1,143,992		1,143,992	(46,652)	1,097,340		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,880,724	498,690	1,569,118	4,948,532		4,948,532	(51,614)	4,896,918		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			33,589	33,589		33,589	184,045	217,634			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,257	6,257		6,257	335,846	342,103			32
33	Real Estate Taxes							49,368	49,368			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(660,000)				34
35	Rent-Equipment & Vehicles			800	800		800	1,045	1,845			35
36	Other (specify):* Mortgage Insurance							30,294	30,294			36
37	TOTAL Ownership			700,646	700,646		700,646	(59,402)	641,244			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,581		221,581		221,581		221,581			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Non-allowable cost			43,336	43,336		43,336	(43,336)				43
44	TOTAL Special Cost Centers		221,581	125,461	347,042		347,042	(43,336)	303,706			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,880,724	720,271	2,395,225	5,996,220		5,996,220	(154,352)	5,841,868			45

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

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	31,332	30		9
10	Interest and Other Investment Income	(53,405)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(470)	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	(435)	43		18
19	Entertainment				19
20	Contributions	(725)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,921)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,162)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(20,623)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,409)		\$	30

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	
		Amount	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)	(88,943)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (88,943)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (154,352)		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	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing & Rehabilitation Center

ID# 0039644

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Lab Expense Med A	\$ (9,183)	43	1
2	X Ray Expense Med A	(11,440)	43	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
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26				26
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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	(20,623)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
1	V	19 Professional Services	\$	Caseyville Property LLC	100.00%	\$ 16,087	\$ 16,087	1
2	V	26 Insurance		Caseyville Property LLC	100.00%	4,216	4,216	2
3	V	30 Depreciation		Caseyville Property LLC	100.00%	150,158	150,158	3
4	V	32 Interest		Caseyville Property LLC	100.00%	384,516	384,516	4
5	V	32 Interest Income	49	Caseyville Property LLC	100.00%		(49)	5
6	V	33 Real Estate Taxes		Caseyville Property LLC	100.00%	45,859	45,859	6
7	V	34 Rent	660,000	Caseyville Property LLC	100.00%		(660,000)	7
8	V	36 Mortgage Insurance		Caseyville Property LLC	100.00%	30,294	30,294	8
9	V	32 Amortization		Caseyville Property LLC	100.00%	4,784	4,784	9
10	V	20 Dues Fees Subscriptions		Caseyville Property LLC	100.00%	250	250	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 660,049			\$ 636,164	\$ * (23,885)	14

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

Caseyville Nursing & Rehabilitation Center

Provider #: 0039644
1/1/2009 to 12/31/2009

VII Related Parties - Page 6

Schedule 6A

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

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehabilitation Center, Inc.

Provider #: 0039644

1/1/2009 to 12/31/2009

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

Beauvais Manor Healthcare and Rehab	St. Louis, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

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

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

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Management Co.	100.00%	\$ 15	\$	15
16	V	3 Housekeeping		SW Management Co.	100.00%	250		250
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,456		1,456
18	V	6 Maintenance		SW Management Co.	100.00%	724		724
19	V	17 Administrative	181,605	SW Management Co.	100.00%	47,800		(133,805)
20	V	19 Professional Services		SW Management Co.	100.00%	4,110		4,110
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	135		135
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	40,406		40,406
23	V	24 Travel and Seminar		SW Management Co.	100.00%	15		15
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	1,224		1,224
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	499		499
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	15,231		15,231
27	V	30 Depreciation		SW Management Co.	100.00%	2,555		2,555
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,509		3,509
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,045		1,045
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		\$ 181,605			\$ 118,974	\$ *	(62,631)

* 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	\$ 17,380	S & E Medical Supply Co.	100.00%	\$ 13,710	\$ (3,670)
16	V	3 Housekeeping	520	S & E Medical Supply Co.	100.00%	520	
17	V	10 Medical Supplies	5,088	S & E Medical Supply Co.	100.00%	6,331	1,243
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 22,988			\$ 20,561	\$ * (2,427)

* 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: 01/01/09 Ending: 12/31/09

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	3	7.50	Salary	\$ 14,340	L17, C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	5	10.00	Salary&Fees	19,120	L17, C7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	3	7.50	Salary	14,340	L17, C7	3
4											4
5											5
6											6
7											7
8	Note:All individuals work in excess of 40 hours per week.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,800		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

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

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

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	2	Food	Bed Days Available	657,730	11	\$ 177	\$ 54,750	\$ 15	1	
2	3	Housekeeping	Bed Days Available	657,730	11	3,004	54,750	250	2	
3	5	Heat and Other Utilities	Bed Days Available	657,730	11	17,488	54,750	1,456	3	
4	6	Maintenance	Bed Days Available	657,730	11	8,697	54,750	724	4	
5	19	Professional Services	Bed Days Available	657,730	11	49,378	54,750	4,110	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,730	11	1,616	54,750	135	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,730	11	485,405	432,056	54,750	40,406	7
8	24	Travel and Seminar	Bed Days Available	657,730	11	186	54,750	15	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,730	11	14,707	54,750	1,224	9	
10	26	Insurance-Prop.Liab.& Malp	Bed Days Available	657,730	11	5,991	54,750	499	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,730	11	182,974	54,750	15,231	11	
12	33	Real Estate Taxes	Bed Days Available	657,730	11	42,159	54,750	3,509	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,730	11	12,559	54,750	1,045	13	
14									14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	40	11	382,400	382,400	3	28,680	17
18	17	Administrative	Avg. Hours Worked	50	6	191,200	191,200	5	19,120	18
19									19	
20	30	Depreciation	Direct Cost						2,555	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,397,941	\$ 1,005,656	\$ 118,974	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	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	2	Food	Direct Cost		\$	\$		\$ 13,710	1
2	3	Housekeeping	Direct Cost					520	2
3	10	Medical Supplies	Direct Cost					6,331	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				\$	\$		\$ 20,561	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 6,020,724	12/1/36	0.0635	\$ 384,516	1								
2												2								
3							Amortization of Mortgage Costs				4,784	3								
4												4								
5												5								
Working Capital																				
6	N/P Stockholders	X		Working Capital		7/31/07			8/5/13	Variable	6,257	6								
7												7								
8												8								
9	TOTAL Facility Related				\$38,896.00		\$ 6,814,000	\$ 6,020,724			\$ 395,557	9								
B. Non-Facility Related*																				
10												10								
11												11								
12							Interest income offset				(53,405)	12								
13							Interest income offset from Real Estate Entity				(49)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (53,454)	14								
15	TOTALS (line 9+line14)						\$ 6,814,000	\$ 6,020,724			\$ 342,103	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 30,294 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.		\$	99,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2008	\$	71,359	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(27,641)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	73,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
	Allocated from Management Co.		3,509	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	49,368	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	84,745	8	
	2005	88,605	9	
	2006	94,408	10	
	2007	96,110	11	
	2008	71,359	12	
2009 Tax Accrual = 71,359 X 1.03 = 73,500.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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 & Rehabilitation Center

0039644

Report Period Beginning:

01/01/09

Ending:

12/31/09

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.

(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: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Resident Care, 2001, \$350,000. Row 2: (blank). Row 3: TOTALS, \$350,000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	2001		\$ 5,265,179	\$	39	\$ 146,726	\$ 146,726	\$ 1,179,380	4
5										5
6										6
7	Management Allocation	1995		36,031		39	1,029	1,029	15,086	7
8										8
Improvement Type**										
9	Various		1994	22,302	192	20	1,116	924	16,998	9
10	Various		1995	52,604	107	20	2,630	2,523	38,181	10
11	Various		1996	2,492		20	125	125	1,809	11
12	Various		1997	11,349	43	20	567	524	7,096	12
13	Various		1998	14,511	227	20	726	499	9,198	13
14	Various		1999	83,394	613	20	4,170	3,557	43,849	14
15	Parking Lot		2000	2,830	167	20	142	(26)	1,322	15
16	Sprinkler System		2000	3,385	87	20	169	82	1,636	16
17	Sprinkler System		2000	5,820	149	20	291	142	2,837	17
18	A/C Repairs		2000	1,018		10	102	102	977	18
19	Ac Repairs		2000	1,102		20	55	55	528	19
20	Draperies		2000	1,052		20	53	53	487	20
21	Carpeting		2000	1,578		20	79	79	764	21
22	Air Handler		2000	1,786		20	89	89	849	22
23	Air Conditioner		2000	1,963		7			1,324	23
24	Air Handler		2000	1,241		20	62	62	589	24
25	Air Conditioner		2000	1,029		20	51	51	496	25
26	Compressor		2000	1,800		20	90	90	900	26
27	Booster Heater		2000	1,675		20	84	84	839	27
28	Air Conditioner		2000	5,821		20	291	291	2,716	28
29	Air Conditioner		2000	17,320		20	866	866	8,299	29
30	Air Conditioner		2001	3,630		20	182	182	1,574	30
31	Air Conditioner		2001	3,630		20	182	182	1,574	31
32	Air Conditioner		2001	3,111		20	156	156	1,349	32
33	Blinds		2001	1,212		20	61	61	536	33
34	Sprinkler Repair		2001	1,609		20	80	80	710	34
35	Sprinkler Heads		2001	2,145		20	107	107	929	35
36	Pipes Repair		2001	1,903		20	95		769	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dining Room Wall	2002	\$ 10,650	\$ 191	10	\$ 1,065	\$ 874	\$ 8,165	37
38	Water Heater	2002	4,900		12	408	408	3,233	38
39	Circuit Breaker	2002	1,390		10	139	139	1,089	39
40	Air Conditioners	2002	2,890		7	206	206	2,856	40
41	Air Conditioners	2002	4,284		7	306	306	4,284	41
42	Water Heater	2002	2,249		12	187	187	1,343	42
43	Doors	2003	9,995	256	20	500	244	3,499	43
44	Dry Value System	2003	5,623	144	20	281	137	1,851	44
45	Landscaping	2003	8,800	520	20	440	(80)	2,787	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	10,646	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	594	47
48	P.A. Amplifier	2003	713		20	36	36	250	48
49	Security Systems	2004	23,268	846	20	1,163	317	6,399	49
50	16 Transmitters	2004	1,517	55	20	76	21	417	50
51	Nurses Stations	2004	35,000	1,273	20	1,750	477	9,625	51
52	Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	12,851	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	19,336	53
54	Air Conditioners	2005	20,666	2,381	7	4,133	1,752	18,599	54
55	Freezer Door	2005	2,100		20	105	105	473	55
56	Wallpaper	2005	16,140		5	3,228	3,228	14,526	56
57	Sprinkler System	2005	5,545	202	20	277	75	1,248	57
58	Painting and Wallcovering	2005	38,520		5	7,704	7,704	34,668	58
59	Air Condensers	2005	6,270	228	20	314	86	1,411	59
60	Vinyl Flooring	2005	5,009	182	5	1,002	820	4,508	60
61	Paving and Sealing Sidewalks	2005	7,000	485	15	467	(18)	2,100	61
62	Metal Doors	2005	1,926	70	20	96	26	433	62
63	Kitchen Floor	2006	10,300	375	20	515	140	1,803	63
64	Sprinkler System	2006	9,529	346	20	476	130	1,668	64
65	Door Monitors & Paging System	2006	811	29	20	41	12	142	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	732	66
67	6 A/C Units	2006	2,576	296	20	129	(167)	451	67
68	6 A/C Units	2006	2,576	297	20	129	(168)	451	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	826	69
70	TOTAL (lines 4 thru 69)		\$ 5,973,031	\$ 14,909		\$ 194,460	\$ 179,456	\$ 1,516,858	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,973,031	\$ 14,909		\$ 194,460	\$ 179,551	\$ 1,516,858	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	648	2
3	Duct Heater	2006	1,349	49	20	67	18	236	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	1,612	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,105	20	2,895	790	7,238	5
6	4 Hot Water Heaters	2007	13,462	490	20	673	183	1,683	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	4,931	7
8	Repair Sprinkler System	2007	3,957	144	20	198	54	495	8
9	Oak flooring	2008	15,571	566	20	779	213	1,168	9
10	Fire alarm system	2008	8,858	322	20	443	121	664	10
11	Street and parking lot paving	2008	43,360	2,060	20	2,168	108	3,252	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	354	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	2,963	13
14	Replace pipe and fitting	2009	4,232	32	20	106	74	106	14
15									15
16									16
17									17
18	Allocation from SW management - leasehold improvements	1995	3,844		20	192	192	3,088	18
19	Allocation from SW management - leasehold improvements	1996	671		20	34	34	455	19
20	Allocation from SW management - leasehold improvements	1997	967		20	48	48	724	20
21	Allocation from SW management - leasehold improvements	1998	666		20	33	33	391	21
22	Allocation from SW management - leasehold improvements	1999	1,848		20	92	92	932	22
23	Allocation from SW management - leasehold improvements	2005	3,823		20	191	191	860	23
24	Allocation from SW management - leasehold improvements	2007	2,164		20	108	108	271	24
25	Allocation from SW management - leasehold improvements	2009	4,518		20	113	113	113	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,236,803	\$ 24,189		\$ 207,429	\$ 183,240	\$ 1,549,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
71	Purchased in Prior Years	\$ 946,817	\$ 1,582	\$ 9,101	\$ 7,519		\$ 861,202	71
72	Current Year Purchases	7,818	7,818	391	(7,427)		391	72
73	Fully Depreciated Assets	123,813					123,813	73
74	Allocated from Management Co.	11,375		231	231		8,569	74
75	TOTALS	\$ 1,089,823	\$ 9,400	\$ 9,723	\$ 323		\$ 993,975	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management	Cadillac	2004	\$ 4,825	\$	\$ 482	\$ 482		\$ 4,825	76
77										77
78										78
79										79
80	TOTALS			\$ 4,825	\$	\$ 482	\$ 482		\$ 4,825	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)	\$ 7,681,451	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,589	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 217,634	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 184,045	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,547,841	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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? YES NO

If NO, see instructions.

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 800 Description: Plumbing Equipment-\$800

(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>Allocated from Management Co.</u>		\$	\$ <u>1,045</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,045</u>	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</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 CNA _____</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 CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	L10A, C3	hrs	\$	3,902	\$ 280,946	\$	3,902	\$ 280,946	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,437	116,978		2,437	116,978	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		3,974	254,323		3,974	254,323	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				221,581		221,581	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			\$	10,313	\$ 652,247	\$ 221,581	10,313	\$ 873,828	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 181,327	\$ 311,237	1
2	Cash-Patient Deposits	30,169	30,169	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>7,346</u>)	1,202,780	1,202,780	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,539	6,275	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedue 17A</u>	563,075	722,192	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,981,890	\$ 2,272,653	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		5,301,209	14
15	Leasehold Improvements, at Historical Cost	666,021	935,594	15
16	Equipment, at Historical Cost	439,638	1,094,648	16
17	Accumulated Depreciation (book methods)	(647,505)	(2,547,841)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>See Schedule 17A</u>)		128,772	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 458,154	\$ 5,262,382	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,440,044	\$ 7,535,035	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 97,260	\$ 102,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,485	36,485	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,354	68,354	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,434	9,434	31
32	Accrued Real Estate Taxes(Sch.IX-B)		73,500	32
33	Accrued Interest Payable		31,898	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedue 17A</u>	96,687	96,687	36
37	<u>See Schedue 17A</u>	187,137	91,663	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 495,357	\$ 510,106	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,020,724	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)	\$	\$ 6,020,724	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 495,357	\$ 6,530,830	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,944,687	\$ 1,004,205	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,440,044	\$ 7,535,035	48

Caseyville Nursing & Rehabilitation Center, Inc.

Provider #: 0039644

12/31/2009

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	After	
	Operating	Consolidation
RE Replacement Reserve	-	58,651
RE Escrow-Real Estate Tax	-	100,466
Due from State - Interest	25,196	25,196
Short Term Loan Exchange	537,879	537,879
Total Line 9-Other Current Assets (Specify)	563,075	722,192

Other Long-Term Assets (Specify)

Capitalized Costs	-	167,434
Accumulated Amortization	-	(38,662)
Total Line 22-Other Long-Term Assets (specify)	-	128,772

Other Current Liabilities (Specify)

Insurance Premiums Payable	(1,238)	(1,238)
Acc. Retirement (From P/R)	450	450
Accrued Expenses	(95,899)	(95,899)
Total Line 36-Other Current Liabilities (Specify)	(96,687)	(96,687)

Due from State	(91,663)	(91,663)
Due/From Caseyville Prop. LLC	(95,474)	-
Total Line 37-Other Current Liabilities (Specify)	(187,137)	(91,663)

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,588,597	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,588,597	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	656,311	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	(300,220)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 356,090	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)	\$ 1,944,687	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,884,584	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,884,584	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	682,034	6
7	Oxygen	19,500	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 701,534	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***	53,405	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,405	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,432	28
28a	Medicaid Income Adjustment	11,576	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,008	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,652,531	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,174,577	31
32	Health Care	2,629,963	32
33	General Administration	1,143,992	33
	B. Capital Expense		
34	Ownership	700,646	34
	C. Ancillary Expense		
35	Special Cost Centers	264,917	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,996,220	40
41	Income before Income Taxes (line 30 minus line 40)**	656,311	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 656,311	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/09

Ending: 12/31/09

12/31/09

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	2,012	2,254	\$ 68,953	\$ 30.59	1
2	Assistant Director of Nursing	1,872	2,077	57,024	27.45	2
3	Registered Nurses	1,932	2,043	53,922	26.39	3
4	Licensed Practical Nurses	26,126	27,547	578,833	21.01	4
5	CNAs & Orderlies	82,223	87,357	858,241	9.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,977	8,739	111,456	12.75	8
9	Activity Director					9
10	Activity Assistants	5,421	5,961	73,491	12.33	10
11	Social Service Workers	3,459	3,751	53,614	14.29	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,088	38,393	18.39	13
14	Head Cook	9,419	10,453	111,627	10.68	14
15	Cook Helpers/Assistants	9,577	10,202	88,576	8.68	15
16	Dishwashers					16
17	Maintenance Workers	5,555	6,129	90,835	14.82	17
18	Housekeepers	10,473	11,349	103,848	9.15	18
19	Laundry	16,554	17,679	142,353	8.05	19
20	Administrator	1,760	2,080	79,318	38.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,817	14,109	370,240	26.24	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)	199,033	213,818	\$ 2,880,724 *	\$ 13.47	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	Monthly	\$ 3,826	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,982	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	36,223	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	98	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 52,729		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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
<u>Geralyn Isenberg</u>	<u>Administrator</u>	<u>0</u>	\$ <u>79,318</u>	<u>Workers' Compensation Insurance</u>	\$ <u>38,192</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>35,452</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>220,474</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>53,591</u>	(Indicate # of checks performed <u>45</u>)	<u>535</u>	
				<u>Employee Meals</u>	<u>4,980</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Council on Long Term Care</u>	<u>16,125</u>	
				<u>Miscellaneous Employee Benefits</u>	<u>1,710</u>	<u>Miscellaneous Dues & Permits</u>	<u>4,517</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>79,318</u>			<u>Miscellaneous Inspections & Licenses</u>	<u>475</u>	
(List each licensed administrator separately.)						<u>Allocated from Management Co.</u>	<u>135</u>	
B. Administrative - Other						<u>Allocated from RE Entity</u>	<u>250</u>	
Description			Amount			<u>Less: Public Relations Expense</u>	()	
<u>SW Management Co.-Home Office</u>			\$ <u>61,605</u>			<u>Non-allowable advertising</u>	()	
<u>Management Fees</u>			<u>120,000</u>			<u>Yellow page advertising</u>	()	
<u>(Eliminated on Schedule V, Column 7)</u>								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>181,605</u>	TOTAL (agree to Schedule V,	\$ <u>354,399</u>	TOTAL (agree to Sch. V,	\$ <u>24,027</u>	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
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	
<u>Helper Broom LLC</u>	<u>Legal</u>	\$ <u>28,603</u>				<u>Out-of-State Travel</u>	\$	
<u>Frederick S. Frankel</u>	<u>Legal</u>	<u>475</u>	<u>N/A</u>					
<u>Stone MacGuire & Siegel</u>	<u>Legal</u>	<u>5,183</u>				<u>In-State Travel</u>		
<u>McGladrey & Pullen LLP</u>	<u>Accounting</u>	<u>17,271</u>						
<u>Frost Ruttenberg & Rothblatt</u>	<u>Accounting</u>	<u>974</u>						
<u>Honkamp & Krueger Co.</u>	<u>Accounting</u>	<u>1,721</u>				<u>Seminar Expense</u>	<u>1,410</u>	
<u>Personnel Planners, Inc.</u>	<u>U/E Consultant</u>	<u>2,480</u>				<u>Allocated from Management Co.</u>	<u>15</u>	
						<u>Entertainment Expense</u>	()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>56,707</u>	TOTAL	\$	(agree to Sch. V,		
(If total legal fees exceed \$5,000, attach copy of invoices.)						line 24, col. 8)	\$ <u>1,425</u>	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Caseyville Nursing & Rehabilitation Center, Inc.

Provider # : 0039644

12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3) 56,707

Allocated from Real Estate Entity - Accounting

- Legal 8,412

- Accounting 7,675

Allocated from Mangement Company

- Legal 2,603

- Accounting 1,507

Total (Agree to Schedule V, Line 19, Column 8) 76,904

SEE ACCOUNTANTS' COMPILATION REPORT

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/09

Ending:

12/31/09

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-\$16,125
- (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. \$ 1,112 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 4,980 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