FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0039644

Facility Name: Caseyville Nrsg & Rehab Ctr

Address: 601 West Lincoln Ave (Number) Caseyville (City) 62232 (Zip Code)

County: St Clair

Telephone Number: (618) 345-3072 **Fax #** (847) 345-3170

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Sheldon Wolfe
(Title) Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,063	1,314	3,970	8,347	8
9	SNF/PED					9
10	ICF	23,233	5,031	7,751	36,015	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,296	6,345	11,721	44,362	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.03%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3,317

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	264,124	36,137	6,420	306,681		306,681		306,681			1
2	Food Purchase		315,147		315,147		315,147	(7,975)	307,172			2
3	Housekeeping	150,642	54,060		204,702		204,702	36	204,738			3
4	Laundry	113,952	20,012		133,964		133,964		133,964			4
5	Heat and Other Utilities			181,630	181,630		181,630	1,312	182,942			5
6	Maintenance	108,931	65,318	21,862	196,111		196,111	294	196,405			6
7	Other (specify):*											7
8	**TOTAL General Services**	637,649	490,674	209,912	1,338,235		1,338,235	(6,333)	1,331,902			8
	B. Health Care and Programs											
9	Medical Director			6,206	6,206		6,206		6,206			9
10	Nursing and Medical Records	1,831,929	99,862	13,368	1,945,159		1,945,159	1,467	1,946,626			10
10a	Therapy	97,130			97,130		97,130		97,130			10a
11	Activities	80,255	12,276		92,531		92,531		92,531			11
12	Social Services	35,163			35,163		35,163		35,163			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,044,477	112,138	19,574	2,176,189		2,176,189	1,467	2,177,656			16
	C. General Administration											
17	Administrative	92,800		324,000	416,800		416,800	(286,160)	130,640			17
18	Directors Fees											18
19	Professional Services			36,554	36,554		36,554	807	37,361			19
20	Dues, Fees, Subscriptions & Promotions			15,651	15,651		15,651	(3,483)	12,168			20
21	Clerical & General Office Expenses	479,972		44,486	524,458		524,458	51,187	575,645			21
22	Employee Benefits & Payroll Taxes			387,531	387,531		387,531	5,914	393,445			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,569	1,569		1,569	139	1,708			24
25	Other Admin. Staff Transportation			32,635	32,635		32,635	1,802	34,437			25
26	Insurance-Prop.Liab.Malpractice			122,678	122,678		122,678	18,643	141,321			26
27	Other (specify):* Mgmt Alloc of Benefi							17,206	17,206			27
28	**TOTAL General Administration**	572,772		965,104	1,537,876		1,537,876	(193,945)	1,343,931			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,254,898	602,812	1,194,590	5,052,300		5,052,300	(198,811)	4,853,489			29

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr #0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			35,721	35,721		35,721	186,641	222,362			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116	116		116	184,905	185,021			32
33	Real Estate Taxes							54,509	54,509			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)				34
35	Rent-Equipment & Vehicles							992	992			35
36	Other (specify):* Mortgage Insurance							29,438	29,438			36
37	TOTAL Ownership			599,837	599,837		599,837	(107,515)	492,322			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		133,442	731,830	865,272		865,272		865,272			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			332,148	332,148		332,148		332,148			42
43	Other (specify):* Non-Allowable Cos			133,001	133,001		133,001	(133,001)				43
44	TOTAL Special Cost Centers		133,442	1,196,979	1,330,421		1,330,421	(133,001)	1,197,420			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,254,898	736,254	2,991,406	6,982,558		6,982,558	(439,327)	6,543,231			45

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,444	30		9
10	Interest and Other Investment Income	(36,188)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(404)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,770)	43		18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,527)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,953)	43		24
25	Fund Raising, Advertising and Promotional	(431)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(19,000)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(108,114)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (171,343)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(267,984)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (267,984)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (439,327)		37

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

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

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

Caseyville Nrsg & Rehab Ctr

ID# 0039644

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (10,278)	43	1
2	X Ray Expense Med A	(12,570)	43	2
3	Managed Care Cost	(77,151)	43	3
4	Collections	(44)	43	4
5	Offset Miscellaneous Income	(4,128)	21	5
6	Lobbying Expense	(3,943)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(108,114)		49

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Caseyville Property LLC	100.00%	$ 8,425	$ 8,425	1
2	V	20	Dues, Fees, Subs. & Promotions		Caseyville Property LLC	100.00%	250	250	2
3	V	26	Insurance-Prop.Liab.Malpractice		Caseyville Property LLC	100.00%	17,639	17,639	3
4	V	30	Depreciation		Caseyville Property LLC	100.00%	171,976	171,976	4
5	V	32	Interest	255	Caseyville Property LLC	100.00%	217,776	217,521	5
6	V	32	Amortization		Caseyville Property LLC	100.00%	3,572	3,572	6
7	V	33	Real Estate Taxes		Caseyville Property LLC	100.00%	47,515	47,515	7
8	V	34	Rent	564,000	Caseyville Property LLC	100.00%		(564,000)	8
9	V	36	Mortgage Insurance		Caseyville Property LLC	100.00%	29,438	29,438	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 564,255			$ 496,591	$ * (67,664)	14

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Financial Services Company	100.00%	$ 224	$ 224	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	36	36	16
17	V	5	Utilities		SW Financial Services Company	100.00%	1,312	1,312	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	294	294	18
19	V	17	Administrative	324,000	SW Financial Services Company	100.00%	37,840	(286,160)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,462	1,462	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	210	210	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	55,315	55,315	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	139	139	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	1,802	1,802	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	1,004	1,004	25
26	V	27	Other		SW Financial Services Company	100.00%	17,206	17,206	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	3,221	3,221	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	3,441	3,441	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	992	992	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			$ 324,000			$ 124,498	$ * (199,502)	39

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 8,181		100.00%	$ 5,896	$ (2,285)	15
16	V	10	Medical Supplies	449		100.00%	1,916	1,467	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			$ 8,630			$ 7,812	$ * (818)	39

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Abraham J Stern	4.67	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing Supp	Shabbona	Supportive Living	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Sheldon Wolfe	23.67	Green Acres Healthcare Rehab Center	Amboy	SW Financial	Skokie	Bookkeeping/	3
4	Ronnie Klein as Trustee	4.99			Services Co.		Management Comp	4
5	Maurice Aaron	4.67	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Michael Klein Revocable Trust	1.99	Oregon Living & Rehabilitation, LLC	Oregon				6
7	Wanda Bowling	0.67	Prairie Crossing Living & Rehab Center	Shabbona	Groves Community	Independence, MO	Hospice	7
8	Miriam Y Klein as Trustee	6.67			Hospice			8
9	Michael A Klein as Trustee	6.67	Tower Hill Rehabilitation LLC	South Elgin	Forest View Senior	Independence, MO	Independent	9
10	Kenneth Klein	4.99			Residences		Living	10
11	Susat Stern	4.67	Beauvais Manor Healthcare and Rehab	St. Louis, MO	White Oak Living	Independence, MO	Residential	11
12	Jonathan B Stern 2001 Trust	1.56	Hillside Manor Healthcare and Rehab	St. Louis, MO	Center		Care	12
13	Todd A. Stern 2001 Trust	1.56	Rancho Manor Healthcare and Rehab	Florissant, MO				13
14	Evan M. Stern	1.56	Rosewood Health & Rehab	Independence, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15	Moshe Herman	0.67	Seasons Care Center	Kansas City, MO	Program LLC			15
16	Ora Aaron	4.67	Carriage Square Living & Rehab	St. Joseph, MO				16
17					Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20								20
21					Franklin Grove	Franklin Grove	Real Estate	21
22					Associates			22
23					Oregon Associates	Oregon	Real Estate	23
24					Shabbona Building	Shabbona	Real Estate	24
25					Associates LLC			25
26								26
27					Tower Hill Property L	South Elgin	Real Estate	27
28								28
29								29
30								30

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	15
16								16
17					Carriage Square Prop	St. Joseph, MO	Real Estate	17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	5.5	12.22	Salary	$ 19,983	L17, C7	1
2											2
3											3
4											4
5											5
6			Note: Mr. Wolfe works in excess of 40 hours per week.								6
7											7
8			See attached schedule 7A for additional compensation information.								8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,983		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 Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	663,601	13	$ 2,712	$	54,750	$ 224	1
2	3	Housekeeping	Bed Days Available	663,601	13	434		54,750	36	2
3	5	Utilities	Bed Days Available	663,601	13	15,908		54,750	1,312	3
4	6	Maintenance	Bed Days Available	663,601	13	3,567		54,750	294	4
5	19	Professional Services-Legal	Bed Days Available	663,601	13	1,827		54,750	151	5
6	19	Professional Services-Other	Bed Days Available	663,601	13	15,885		54,750	1,311	6
7	20	Dues, Fees, Subs. & Promotions	Bed Days Available	663,601	13	2,546		54,750	210	7
8	21	Clerical & General Office Expens	Bed Days Available	663,601	13	549,341	549,341	54,750	45,323	8
9	21	Clerical & General Office Expens	Bed Days Available	663,601	13	121,114		54,750	9,992	9
10	24	Travel & Seminar	Bed Days Available	663,601	13	1,687		54,750	139	10
11	25	Other Admin. Staff Transportion	Bed Days Available	663,601	13	21,838		54,750	1,802	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	663,601	13	12,166		54,750	1,004	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	663,601	13	208,541		54,750	17,206	13
14	33	Real Estate Taxes	Bed Days Available	663,601	13	41,712		54,750	3,441	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	663,601	13	12,022		54,750	992	15
16										16
17	17	Administrative - Salary	Average Hours Worked	45	13	163,500	163,500	6	19,983	17
18	17	Administrative - Salary	Average Hours Worked	45	13	146,104	146,104	6	17,857	18
19										19
20	30	Depreciation	Direct Cost	39,045					3,221	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,320,904	$ 858,945		$ 124,498	25

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 5,896	1
2	10	Medical Supplies	Direct Cost						1,916	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					$	$		$ 7,812	25

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage	$38,896.00	11/27/01	$ 6,814,000	$ 5,823,945	12/1/36	0.0635	$ 217,776	1
2												2
3	Amortization of Mortgage Cost										3,572	3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit	Demand	1/31/12	1,150,000		1/15/13	0.0425		6
7	Late Payment Fees										116	7
8												8
9	TOTAL Facility Related				$38,896.00		$ 7,964,000	$ 5,823,945			$ 221,464	9
	B. Non-Facility Related*											
10												10
11								Disallow Late Payment Fees			(116)	11
12								Interest Income			(36,327)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (36,443)	14
15	TOTALS (line 9+line14)						$ 7,964,000	$ 5,823,945			$ 185,021	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 29,438 **Line #** 36

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

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 72,664	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.)	2013	$ 58,624	2
3. Under or (over) accrual (line 2 minus line 1).		$ (14,040)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 61,555	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.)		$ 3,553	5
	Allocated from Managment Co.	3,441	
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.		$ 54,509	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	74,520	8
	2010	73,391	9
	2011	69,693	10
	2012	59,284	11
	2013	58,624	12

2014 Tax Accrual = 58,624*1.05 = 61,555

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Caseyville Nrsg & Rehab Ctr COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0039644

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

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

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-07.0-300-005	Long Term Property Care	$ 58,624.34	$ 58,624.34
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 39,795.50	$ 3,083.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 98,419.84	$ 61,707.34

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2001		$ 5,265,179	$	39	$ 146,726	$ 146,726	$ 1,913,010	4
5											5
6											6
7											7
8	Allocated from Management Co.		1995		33,529			958	958	18,829	8
	Improvement Type**										
9	Various			1994	22,304	58	20	861	803	22,304	9
10	Various			1995	52,604	107	20	2,630	2,523	51,331	10
11	Various			1996	2,492		20	125	125	2,434	11
12	Various			1997	11,349	43	20	567	524	9,931	12
13	Various			1998	14,511	227	20	726	499	12,828	13
14	Various			1999	83,394	613	20	4,170	3,557	64,699	14
15	Parking Lot			2000	2,830	167	20	142	(25)	2,032	15
16	Sprinkler System			2000	3,385	87	20	169	82	2,481	16
17	Sprinkler System			2000	5,820	149	20	291	142	4,292	17
18	A/C Repairs			2000	1,018		10			1,018	18
19	Ac Repairs			2000	1,102		20	55	55	803	19
20	Draperies			2000	1,052		20	53	53	752	20
21	Carpeting			2000	1,578		20	79	79	1,159	21
22	Air Handler			2000	1,786		20	89	89	1,294	22
23	Air Conditioner			2000	1,963		7			1,324	23
24	Air Handler			2000	1,241		20	62	62	899	24
25	Air Conditioner			2000	1,029		20	51	51	751	25
26	Compressor			2000	1,800		20	90	90	1,350	26
27	Booster Heater			2000	1,675		20	84	84	1,259	27
28	Air Conditioner			2000	5,821		20	291	291	4,171	28
29	Air Conditioner			2000	17,320		20	866	866	12,629	29
30	Air Conditioner			2001	3,630		20	182	182	2,484	30
31	Air Conditioner			2001	3,630		20	182	182	2,484	31
32	Air Conditioner			2001	3,111		20	156	156	2,129	32
33	Blinds			2001	1,212		20	61	61	841	33
34	Sprinkler Repair			2001	1,609		20	80	80	1,110	34
35	Sprinkler Heads			2001	2,145		20	107	107	1,464	35
36	Pipes Repair			2001	1,903		20	95		1,244	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dining Room Wall	2002	$ 10,650	$ 191	10	$	$ (191)	$ 10,650	37
38	Water Heater	2002	4,900		12	35	35	4,900	38
39	Circuit Breaker	2002	1,390		10			1,390	39
40	Air Conditioners	2002	2,890		7			2,855	40
41	Air Conditioners	2002	4,284		7			4,284	41
42	Water Heater	2002	2,249		12	158	158	2,249	42
43	Doors	2003	9,995	256	20	500	244	5,999	43
44	Dry Value System	2003	5,623	144	20	281	137	3,256	44
45	Landscaping	2003	8,800	520	20	440	(80)	4,987	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	19,396	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	1,019	47
48	P.A. Amplifier	2003	713		20	36	36	430	48
49	Security Systems	2004	23,268	846	20	1,163	317	12,214	49
50	16 Transmitters	2004	1,517	55	20	76	21	797	50
51	Nurses Stations	2004	35,000	1,273	20	1,750	477	18,375	51
52	Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	24,536	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	40,821	53
54	Air Conditioners	2005	20,666		7			20,666	54
55	Freezer Door	2005	2,100		20	105	105	998	55
56	Wallpaper	2005	16,140		5			16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	2,633	57
58	Painting and Wallcovering	2005	38,520		5			38,520	58
59	Air Condensors	2005	6,270	228	20	314	86	2,981	59
60	Vinyl Flooring	2005	5,009	182	5		(182)	5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	413	15	467	54	4,435	61
62	Metal Doors	2005	1,926	70	20	96	26	913	62
63	Kitchen Floor	2006	10,300	375	20	515	140	4,378	63
64	Sprinkler System	2006	9,529	346	20	476	130	4,048	64
65	Door Monitors & Paging System	2006	811	29	20	41	12	347	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	1,777	66
67	6 A/C Units	2006	2,576		20	129	129	1,096	67
68	6 A/C Units	2006	2,576		20	129	129	1,096	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	2,006	69
70	TOTAL (lines 4 thru 69)		$ 5,970,531	$ 11,729		$ 175,850	$ 164,026	$ 2,408,537	70

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,970,531	$ 11,729		$ 175,850	$ 164,121	$ 2,408,537	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	1,573	2
3	Duct Heater	2006	1,349	49	20	67	18	571	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	3,917	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,105	20	2,895	790	21,713	5
6	4 Hot Water Heaters	2007	13,462	490	20	673	183	5,048	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	14,796	7
8	Repair Sprinkler System	2007	3,957	144	20	198	54	1,485	8
9	Oak flooring	2008	15,571	566	20	779	213	5,063	9
10	Fire alarm system	2008	8,858	322	20	443	121	2,879	10
11	Street and parking lot paving	2008	43,360	1,280	20	2,168	888	14,092	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	1,534	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	12,838	13
14	Replace pipe and fitting	2009	4,232	154	20	212	58	1,166	14
15	Air Handling Equipment	2010	22,154	806	20	1,108	302	4,986	15
16	Plumbing Value	2011	4,600	167	20	230	63	805	16
17	Hot water system	2011	6,900	251	20	345	94	1,208	17
18	Sprinkler Work	2011	20,035	729	20	1,002	273	3,924	18
19	Direct TV system Installation	2011	7,000		20	350	350	1,225	19
20	Handicap shower stall	2011	2,955	107	20	148	41	518	20
21									21
22	71 Gallon Hot Water Heater: Nurse Station Mechanical Room	2012	3,389	123	20	169	46	424	22
23	100 Gallon Hot Water Heater: Dietary/Maint. Electrical Room	2012	4,917	179	20	246	67	615	23
24	Lighting - Electrical Work: All Resident Rooms	2012	9,975	363	20	499	136	1,247	24
25	Fire Alarm: Whole Facility	2012	6,434	234	20	322	88	777	25
26									26
27	81 Gallon Hot Water Heater	2013	4,624		20	661	661	1,266	27
28	New Door	2013	3,094		20	442	442	479	28
29	100 Gallon Hot Water Heater:	2013	6,236		20	891	891	891	29
30									30
31									31
32	Belt Drive Rooftop Ventilator	2014	3,197		20	133	133	133	32
33	Countertop and Back Splash	2014	5,593		20	513	513	513	33
34	TOTAL (lines 1 thru 33)		$ 6,326,905	$ 23,310		$ 195,173	$ 171,863	$ 2,514,221	34

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,326,905	$ 23,310		$ 195,173	$ 171,863	$ 2,514,221	1
2	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	3,752			9	9	3,752	2
3	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	625			31	31	580	3
4	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	724			36	36	723	4
5	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	619			31	31	519	5
6	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,720			86	86	1,297	6
7	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	3,558			178	178	1,690	7
8	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	2,014			101	101	755	8
9	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	4,205			210	210	1,156	9
10	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	2,245			112	112	168	10
11	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	2,264			57	57	57	11
12									12
13	To reconcile to financial statements			(8,273)			8,273		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,348,631	$ 15,037		$ 196,024	$ 180,987	$ 2,524,918	34

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,000,075	$	$ 15,891	$ 15,891	10	$ 888,874	71
72	Current Year Purchases	20,683	20,684	1,034	(19,650)	10	1,034	72
73	Fully Depreciated Assets	166,018					166,018	73
74	Allocated from Management	10,816		221	221		9,055	74
75	TOTALS	$ 1,197,592	$ 20,684	$ 17,146	$ (3,538)		$ 1,064,981	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management	2010 Infiniti	2010	$ 5,957	$	$ 1,191	$ 1,191	5	$ 5,361	76
77	2011 Chevy Express van	2011	2011	40,007		8,001	8,001	5	28,005	77
78										78
79										79
80	TOTALS			$ 45,964	$	$ 9,192	$ 9,192		$ 33,366	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)	$ 7,942,187	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,721	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 222,362	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 186,641	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,623,265	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

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

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Management Co.		$	$ 992	17
18					18
19					19
20					20
21	TOTAL		$	$ 992	21

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

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	4,875	$ 351,004	$	4,875	$ 351,004	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,970	94,538		1,970	94,538	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		4,473	286,288		4,473	286,288	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				110,027		110,027	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					23,415		23,415	12
13	Other (specify):									13
14	TOTAL			$	11,318	$ 731,830	$ 133,442	11,318	$ 865,272	14

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 276,468	$ 423,612	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	2,325,401	2,325,401	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,820	29,876	6
7	Other Prepaid Expenses	4,719	4,719	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	917,684	1,594,810	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,545,092	$ 4,378,418	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		5,298,708	14
15	Leasehold Improvements, at Historical Cost	754,380	1,049,923	15
16	Equipment, at Historical Cost	202,020	1,243,556	16
17	Accumulated Depreciation (book methods)	(519,312)	(3,623,265)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Schedule 17A		78,893	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 437,088	$ 4,397,815	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,982,180	$ 8,776,233	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 64,590	$ 71,615	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,376	31,376	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,690	130,690	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,051	15,051	31
32	Accrued Real Estate Taxes(Sch.IX-B)		61,555	32
33	Accrued Interest Payable		17,909	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	840,471	941,288	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,082,178	$ 1,269,484	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,823,945	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,823,945	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,082,178	$ 7,093,429	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,900,002	$ 1,682,804	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,982,180	$ 8,776,233	48

*(See instructions.)

Facility Name: **Caseyville Nrsg & Rehab Ctr**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/14**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
DUE FROM STATE - INTEREST	139,186	139,186
SHORT TERM LOAN EXCHANGE	689,816	689,816
DUE/FROM CASEYVILLE PROP. LLC	88,682	88,682
RE ESCROW - INSURANCE	-	5,100
RE ESCROW-MIP	-	24,572
RE REPLACEMENT RESERVE	-	291,206
RE ESCROW- REAL ESTATE TAX	-	31,466
RE ESCROW - LITIGATION	-	324,782
Total - Line 9	**917,684**	**1,594,810**

XV. Balance Sheet
Line 22 Other Long Term Assets (specify):

Description	Operating	After Consolidation
CAPITALIZED COSTS	-	89,312
ACCUMILATED AMMORTIZATION	-	(10,419)
Total - Line 9	**-**	**78,893**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
DUE FROM STATE	48,399	48,399
DUE TO STATE PER AUDIT	45,106	45,106
REIMBURSEMENT DUE	2,745	2,745

INSURANCE PREMIUMS PAYABLE	586	12,720
ACCRUED EXPENSES	464,874	464,874
SHORT TERM LOAN EXCHANGE	278,761	278,761
RE DUE TO LESSOR - RELATED PARTY	-	88,683
Total - Line 36	**840,471**	**941,288**

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,976,716	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(805,001)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,171,715	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	883,287	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	45,000	10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Distributions**	(1,200,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (271,713)	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)**	$ 2,900,002	24 *

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,053,810	1
2	Discounts and Allowances for all Levels	(15,537)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,038,273	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	727,735	6
7	Oxygen	24,306	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 752,041	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***	36,072	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,072	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,128	28
28a	Medicaid Income Adjustment	35,331	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,459	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,865,845	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,338,235	31
32	Health Care	2,176,189	32
33	General Administration	1,537,876	33
	B. Capital Expense		
34	Ownership	599,837	34
	C. Ancillary Expense		
35	Special Cost Centers	998,273	35
36	Provider Participation Fee	332,148	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,982,558	40
41	**Income before Income Taxes (line 30 minus line 40)****	883,287	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 883,287	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,473,303	44
45	Private Pay - Net Inpatient Revenue	979,860	45
46	Medicare - Net Inpatient Revenue	1,478,146	46
47	Other-(specify) Hospice	106,964	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,038,273	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.**

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

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

^ - This entity is a cash basis taxpayer

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,080	$ 75,056	$ 36.08	1
2	Assistant Director of Nursing	1,962	2,080	58,026	27.90	2
3	Registered Nurses	3,163	3,329	87,460	26.27	3
4	Licensed Practical Nurses	25,278	27,499	617,561	22.46	4
5	CNAs & Orderlies	82,895	88,758	993,826	11.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,733	7,564	97,130	12.84	8
9	Activity Director					9
10	Activity Assistants	5,447	5,937	80,255	13.52	10
11	Social Service Workers	1,939	2,147	35,163	16.38	11
12	Dietician					12
13	Food Service Supervisor	1,915	2,115	45,047	21.30	13
14	Head Cook	6,175	6,850	84,404	12.32	14
15	Cook Helpers/Assistants	13,805	15,029	134,673	8.96	15
16	Dishwashers					16
17	Maintenance Workers	4,961	5,485	108,931	19.86	17
18	Housekeepers	13,653	14,803	150,642	10.18	18
19	Laundry	11,631	12,568	113,952	9.07	19
20	Administrator	2,040	2,080	92,800	44.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	14,264	15,824	370,122	23.39	23
24	Clerical	5,864	6,282	109,850	17.49	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 Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,621	220,430	$ 3,254,898 *	$ 14.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,420	L1, C3	35
36	Medical Director	Monthly	6,206	L9, C3	36
37	Medical Records Consultant	Monthly	1,113	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,255	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,994		49

C. CONTRACT NURSES

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Geralyn Isenberg	Administrator	0	$ 92,800
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,800

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 204,000
Management Fees	120,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 324,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Field and Goldberg,LLC	Legal	$ 575
Hepler Broom LLC	Legal	3,665
Polsinelli Shughart	Legal	5,558
Allen A. Lefkovitaz & Assoc. P.C.	Legal	3,553
McGladrey LLP	Accounting	18,140
HK Payroll Services Co.	Accounting	4,193
Michigan Peer Review	MDS Consultant	870
See SCH 21C		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 36,554

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,090
Unemployment Compensation Insurance	34,216
FICA Taxes	240,683
Employee Health Insurance	61,702
Employee Meals	5,914
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	1,504
Uniforms	(13)
Employee Life Insurance	349
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,445

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 92)	1,107
Patient Background Checks	
Miscellaneous Inspections & Licenses	199
Miscellaneous Dues & Permits	407
Illinois Council on Long Term Care	11,948
Allocated from Management Co	210
Allocated from RE Entity	250
Less: Public Relations Expense	( )
Non-allowable advertising	(3,943)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,168

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,569
Allocated from Management Co	139
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,708

**See instructions.

Facility Name: **Caseyville Nrsg & Rehab Ctr**
IDPH License ID Number: **0040543**
Fiscal Year End: **12/31/2014**

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Total on Page 21 for Schedule V, line 19, column 3		36,554
	Total (agree to Schedule V, line 19, column 3)	36,554
	Allocated from Real Estate Professional Services	8,425
	Allocated from Management Company Legal Fees	151
	Allocated from Management Company Professional Services	1,311
	Less: Non-Allowable Legal Fees	(5,558)
	Reclass Real Estate Tax Appeal	(3,553)
	To Include Allowable Legal Fees	31
	Total (agree to Schedule V, line 19, column 8)	37,361

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3												N/A	
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/14 Ending: 12/31/14

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-$8,005**

(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. $ **137** 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. $ **332,148**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,914** 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?
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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.