FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0047126

Facility Name: St Anthonys Nsg & Rehab Ctr

Address: 767 30th Street (Number) Rock Island (City) 61201 (Zip Code)

County: Rock Island

Telephone Number: (309) 788 - 7631 **Fax #** (309) 788 - 9823

HFS ID Number:

Date of Initial License for Current Owners: 05/19/05

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Edward N. Slack **Telephone Number:** (847) 628 - 8796
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 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	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	11,508	2,911	4,653	19,072	8
9	SNF/PED					9
10	ICF	17,263	4,366		21,629	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,771	7,277	4,653	40,701	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.78%

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

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

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

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

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 05/19/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/19/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 3,844

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	266,150	55,093	10,508	331,751		331,751		331,751			1
2	Food Purchase		343,318		343,318		343,318		343,318			2
3	Housekeeping	160,679	40,966		201,645		201,645		201,645			3
4	Laundry	63,026	9,802		72,828		72,828		72,828			4
5	Heat and Other Utilities			225,193	225,193		225,193	(12,425)	212,768			5
6	Maintenance	114,774	7,480	140,573	262,827		262,827	5,581	268,408			6
7	Other (specify):* See Supplemental	26,088			26,088		26,088		26,088			7
8	**TOTAL General Services**	630,717	456,659	376,274	1,463,650		1,463,650	(6,844)	1,456,806			8
	B. Health Care and Programs											
9	Medical Director			26,025	26,025		26,025		26,025			9
10	Nursing and Medical Records	2,463,464	288,877	9,351	2,761,692		2,761,692	59,779	2,821,471			10
10a	Therapy											10a
11	Activities	70,358	905		71,263		71,263		71,263			11
12	Social Services	34,228	165	2,097	36,490		36,490		36,490			12
13	CNA Training											13
14	Program Transportation			3,151	3,151		3,151		3,151			14
15	Other (specify):* See Supplemental							9,812	9,812			15
16	**TOTAL Health Care and Programs**	2,568,050	289,947	40,624	2,898,621		2,898,621	69,591	2,968,212			16
	C. General Administration											
17	Administrative	82,017			82,017		82,017	40,151	122,168			17
18	Directors Fees											18
19	Professional Services			730,832	730,832		730,832	(556,365)	174,467			19
20	Dues, Fees, Subscriptions & Promotions			52,086	52,086		52,086	4,687	56,773			20
21	Clerical & General Office Expenses	98,008	18,406	377,745	494,159		494,159	(210,087)	284,072			21
22	Employee Benefits & Payroll Taxes			483,255	483,255		483,255		483,255			22
23	Inservice Training & Education											23
24	Travel and Seminar			165	165		165	1,320	1,485			24
25	Other Admin. Staff Transportation			19,987	19,987		19,987	(2,752)	17,235			25
26	Insurance-Prop.Liab.Malpractice			34,638	34,638		34,638	83,968	118,606			26
27	Other (specify):* See Supplemental							28,288	28,288			27
28	**TOTAL General Administration**	180,025	18,406	1,698,708	1,897,139		1,897,139	(610,790)	1,286,349			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,378,792	765,012	2,115,606	6,259,410		6,259,410	(548,043)	5,711,367			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.

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	26,088		
Total	26,088	-	-
Line 15 Detailed			
SAK Management Services, LLC			
Employee Benefits - HC Services			9,812
Total	-	-	9,812
Line 27 Detailed			
SAK Management Services, LLC			
Employee Benefits - Gen. Admin.			28,288
Total	-	-	28,288

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 3 Line 25 Column 3 Other Staff Admin Travel Supplemental Schedule

Payee	Amount	Non-Allowable
Doris Rex	2,049	
Healthcare Investigators, Inc.	971	971
Laurie Alumbaugh	4,789	
Loretta Price	10,099	
Alloc. - SAK Management Services, LLC	299	
Total	18,206	971
Total Allowable	17,235	

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr #0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			68,058	68,058		68,058	334,202	402,260			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,417	84,417		84,417	520,940	605,357			32
33	Real Estate Taxes							79,152	79,152			33
34	Rent-Facility & Grounds			1,057,548	1,057,548		1,057,548	(1,031,776)	25,772			34
35	Rent-Equipment & Vehicles			10,225	10,225		10,225	2,162	12,387			35
36	Other (specify):* See Supplemental							68,146	68,146			36
37	**TOTAL Ownership**			1,220,248	1,220,248		1,220,248	(27,174)	1,193,074			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		200,679	886,364	1,087,043		1,087,043		1,087,043			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,008	285,008		285,008		285,008			42
43	Other (specify):* See Supplemental	64,900	1,069	2,316	68,285		68,285	(68,285)				43
44	**TOTAL Special Cost Centers**	64,900	201,748	1,173,688	1,440,336		1,440,336	(68,285)	1,372,051			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,443,692	966,760	4,509,542	8,919,994		8,919,994	(643,502)	8,276,492			45

***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

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
SAK Management Services, LLC			
Mortgage Insurance Premiums			68,146
Total	-	-	68,146
Line 43 Detailed			
Marketing	64,900	1,069	2,316
Total	64,900	1,069	2,316

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(12,425)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,020)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(67,600)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(277,183)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(118,497)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (476,725)		$	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)	(166,777)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (166,777)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (643,502)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

St Anthonys Nsg & Rehab Ctr

ID# 0047126

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Assets < $2,500 Expensed	$ 5,581	06	1
2	Legal - Prior Period	(1,864)	19	2
3	Legal - Collections	(4,945)	19	3
4	Medical Records Income	(341)	21	4
5	Other Income	(925)	21	5
6	Bank Charges	(9,228)	21	6
7	Other Admin Staff Transportation	(971)	25	7
8	Marketing	(68,285)	43	8
9				9
10				10
11				11
12				12
13	St. Anthony's Property Partners, LLC			13
14	Professional Fees	(12,445)	19	14
15	Office and Clerical	(500)	21	15
16	Amortization	(24,574)	31	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**	(118,497)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,425)	0	0	0	0	0	0	0	0	0	0	(12,425)	5
6	Maintenance	5,581	0	0	0	0	0	0	0	0	0	0	5,581	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,844)	0	0	0	0	0	0	0	0	0	0	(6,844)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	59,779	0	0	0	0	0	0	0	0	59,779	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	9,812	0	0	0	0	0	0	0	0	9,812	15
16	**TOTAL Health Care and Programs**	0	0	69,591	0	0	0	0	0	0	0	0	69,591	16
	C. General Administration													
17	Administrative	0	0	40,151	0	0	0	0	0	0	0	0	40,151	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(19,254)	12,445	(549,556)	0	0	0	0	0	0	0	0	(556,365)	19
20	Fees, Subscriptions & Promotions	0	0	4,687	0	0	0	0	0	0	0	0	4,687	20
21	Clerical & General Office Expenses	(355,777)	500	145,190	0	0	0	0	0	0	0	0	(210,087)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,320	0	0	0	0	0	0	0	0	1,320	24
25	Other Admin. Staff Transportation	(971)	0	(1,781)	0	0	0	0	0	0	0	0	(2,752)	25
26	Insurance-Prop.Liab.Malpractice	0	72,593	11,375	0	0	0	0	0	0	0	0	83,968	26
27	Other (specify):*	0	0	28,288	0	0	0	0	0	0	0	0	28,288	27
28	**TOTAL General Administration**	(376,002)	85,538	(320,326)	0	0	0	0	0	0	0	0	(610,790)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(382,846)	85,538	(250,735)	0	0	0	0	0	0	0	0	(548,043)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	334,202	0	0	0	0	0	0	0	0	0	334,202	30
31	Amortization of Pre-Op. & Org.	(24,574)	24,574	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,020)	521,960	0	0	0	0	0	0	0	0	0	520,940	32
33	Real Estate Taxes	0	79,152	0	0	0	0	0	0	0	0	0	79,152	33
34	Rent-Facility & Grounds	0	(1,057,548)	25,772	0	0	0	0	0	0	0	0	(1,031,776)	34
35	Rent-Equipment & Vehicles	0	0	2,162	0	0	0	0	0	0	0	0	2,162	35
36	Other (specify):*	0	68,146	0	0	0	0	0	0	0	0	0	68,146	36
37	**TOTAL Ownership**	(25,594)	(29,514)	27,934	0	0	0	0	0	0	0	0	(27,174)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(68,285)	0	0	0	0	0	0	0	0	0	0	(68,285)	43
44	**TOTAL Special Cost Centers**	(68,285)	0	0	0	0	0	0	0	0	0	0	(68,285)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(476,725)	56,024	(222,801)	0	0	0	0	0	0	0	0	(643,502)	45

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
Suzanne Koenig	90%	Lena Living Center, LLC	Lena, Illinois	St. Anthony's		
Gary Weintraub	10%			Property, LLC	Rock Island, Illinois	Bldg. Partnership
				Lena Property		
				Property, LLC	Lena, Illinois	Bldg. Partnership
				SAK Management	Northfield, Illinois	Mgmt. Company

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 [X] 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	34	Rent	$ 1,057,548	St. Anthony's Property Partners, LLC	100.00%	$	$ (1,057,548)	1
2	V	32	Interest	81	St. Anthony's Property Partners, LLC	100.00%		(81)	2
3	V	19	Professional Fees		St. Anthony's Property Partners, LLC	100.00%	12,445	12,445	3
4	V	21	Office and Clerical		St. Anthony's Property Partners, LLC	100.00%	500	500	4
5	V	26	Insurance		St. Anthony's Property Partners, LLC	100.00%	72,593	72,593	5
6	V	30	Depreciation	18,400	St. Anthony's Property Partners, LLC	100.00%	352,602	334,202	6
7	V	31	Amortization		St. Anthony's Property Partners, LLC	100.00%	24,574	24,574	7
8	V	32	Interest		St. Anthony's Property Partners, LLC	100.00%	522,041	522,041	8
9	V	33	Real Estate Taxes		St. Anthony's Property Partners, LLC	100.00%	79,152	79,152	9
10	V	36	Mortgage Insurance		St. Anthony's Property Partners, LLC	100.00%	68,146	68,146	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,076,029			$ 1,132,053	$ * 56,024	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing	$	SAK Management Services, LLC	100.00%	$ 59,779	$ 59,779	15
16	V	15	Emp. Ben. - HC Programs		SAK Management Services, LLC	100.00%	9,812	9,812	16
17	V	17	Administration		SAK Management Services, LLC	100.00%	40,151	40,151	17
18	V	19	Professional Fees	572,983	SAK Management Services, LLC	100.00%	0	(572,983)	18
19	V	19	Professional Fees		SAK Management Services, LLC	100.00%	23,427	23,427	19
20	V	20	Dues, Fees, and Subscriptions		SAK Management Services, LLC	100.00%	4,687	4,687	20
21	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	132,179	132,179	21
22	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	13,011	13,011	22
23	V	24	Travel and Seminar		SAK Management Services, LLC	100.00%	1,320	1,320	23
24	V	25	Other Staff Admin. Transportation		SAK Management Services, LLC	100.00%	299	299	24
25	V	25	Other Staff Admin. Transportation	2,080	SAK Management Services, LLC	100.00%	0	(2,080)	25
26	V	26	Insurance		SAK Management Services, LLC	100.00%	11,375	11,375	26
27	V	27	Emp. Ben. - Gen. Administration		SAK Management Services, LLC	100.00%	28,288	28,288	27
28	V	30	Depreciation		SAK Management Services, LLC	100.00%	0		28
29	V	32	Interest		SAK Management Services, LLC	100.00%	0		29
30	V	34	Rent - Building		SAK Management Services, LLC	100.00%	25,772	25,772	30
31	V	35	Rent - Equipment		SAK Management Services, LLC	100.00%	2,162	2,162	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 575,063			$ 352,262	$ * (222,801)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X]

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

Name of Related Organization: St. Anthony's Property Partners, LLC
Street Address: 767 30th Street
City / State / Zip Code: Rock Island, Illinois 61201
Phone Number: (
Fax Number: (

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X]

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

Name of Related Organization: SAK Management Services, LLC
Street Address: 1 Northfield Plaza, Suite 480
City / State / Zip Code: Northfield, Illinois 60093
Phone Number: (847) 446 - 8400
Fax Number: (847) 446 - 8432

	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	10	Nursing	SAK Consulting Fees	1,667,019		$ 181,661	$ 181,661	548,562	$ 59,779	1
2	15	Emp. Ben. - HC Programs	SAK Consulting Fees	1,667,019		29,819		548,562	9,812	2
3	17	Administration	SAK Consulting Fees	1,667,019		122,013	122,013	548,562	40,151	3
4	19	Professional Fees	Direct	160,528		160,528				4
5	19	Professional Fees	SAK Consulting Fees	1,667,019		71,191		548,562	23,427	5
6	20	Dues, Fees, and Subscriptions	SAK Consulting Fees	1,667,019		14,244		548,562	4,687	6
7	21	Office and Clerical	SAK Consulting Fees	1,667,019		401,678	401,678	548,562	132,179	7
8	21	Office and Clerical	SAK Consulting Fees	1,667,019		39,540		548,562	13,011	8
9	24	Travel and Seminar	SAK Consulting Fees	1,667,019		4,011		548,562	1,320	9
10	25	Other Staff Admin. Transp.	Direct	115,072		115,072		299	299	10
11	25	Other Staff Admin. Transp.	SAK Consulting Fees	1,667,019				548,562		11
12	26	Insurance	SAK Consulting Fees	1,667,019		34,566		548,562	11,375	12
13	27	Emp. Ben. - Gen. Admin.	SAK Consulting Fees	1,667,019		85,963		548,562	28,288	13
14	30	Depreciation	SAK Consulting Fees	1,667,019				548,562		14
15	32	Interest	SAK Consulting Fees	1,667,019				548,562		15
16	34	Rent - Building	SAK Consulting Fees	1,667,019		78,319		548,562	25,772	16
17	35	Rent - Equipment	SAK Consulting Fees	1,667,019		6,569		548,562	2,162	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,345,174	$ 705,352		$ 352,262	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	HUD		X	Mortgage			$ 11,995,400	$ 11,692,581			$ 522,041	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				1,054,177			56,450	6
7	Monroe Capital		X	Line of Credit				186,449			27,967	7
8												8
9	TOTAL Facility Related						$ 11,995,400	$ 12,933,207			$ 606,458	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income		X								(1,020)	12
13	Interest Income - Bldg. Part.		X								(81)	13
14	TOTAL Non-Facility Related						$	$			$ (1,101)	14
15	TOTALS (line 9+line14)						$ 11,995,400	$ 12,933,207			$ 605,357	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 68,146 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.)

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	85,025	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.)	$	79,152	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,873)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	85,025	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
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.	$	79,152	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	83,429	8
	2011	87,094	9
	2012	83,397	10
	2013	80,326	11
	2014	79,152	12

2015 Real Estate Tax Accrual = $79,152 * 1.074 = $85,025

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Anthonys Nsg & Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-231-19-00	Long Term Care Facility	$ 1,335.92	$ 1,335.92
2.	09-430-04-00	Long Term Care Facility	$ 71,052.28	$ 71,052.28
3.	09-430-05-00	Long Term Care Facility	$ 6,764.24	$ 6,764.24
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 79,152.44	$ 79,152.44

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? _____ YES X 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 149,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 5

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

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

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

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

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	319,300	2005	$ 155,000	1
2					2
3	TOTALS	319,300		$ 155,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	130		2005	1974	$ 2,050,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	27,609						9
10	Various			2008	18,233						10
11	Various			2009	4,635						11
12	Various			2010	22,384						12
13	Various			2011	17,892						13
14	Water Heater			2013	16,698						14
15	Fire Protection System			2014	26,285						15
16	Boiler Pump - Parts and Repairs			2014	3,963						16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28	St. Anthony's Property Partners, LLC										28
29											29
30	Complete Facility Rehabilitation and Renovation			2012	6,510,694						30
31	Complete Facility Rehabilitation and Renovation			2013	1,200,533						31
32											32
33											33
34											34
35	Depreciation - St. Anthony's Nursing & Rehab Center, LLC					17,258		17,258		105,046	35
36	Depreciation - St. Anthony's Property Partners, LLC					334,202		334,202		1,423,794	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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 455,844	$ 41,699	$ 41,699	$		$ 178,279	71
72	Current Year Purchases	12,588	3,785	3,785			3,785	72
73	Fully Depreciated Assets							73
74	R.P. Allocations	761,683					741,202	74
75	TOTALS	$ 1,230,115	$ 45,484	$ 45,484	$		$ 923,266	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	Facility	Ford WindStar	2005	$ 1,506	$	$	$		$ 1,506	76
77	Facility	Snow Plow Truck	2010	5,500	317	317			5,500	77
78	Facility	Ford E 350 Bus	2014	15,623	4,999	4,999			8,124	78
79										79
80	TOTALS			$ 22,629	$ 5,316	$ 5,316	$		$ 15,130	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)	$ 11,306,670	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 402,260	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 402,260	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,467,236	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 13 Supplemental Schedule

Description	Cost	Book Depr.	S/L Depr.	Accumulated Depreciation
Related Party 1 - St. Anthony's Property Partners, LLC				
Prior	710,291			710,291
Current				
Total	710,291	-	-	710,291
Related Party 2 - SAK Management Services, LLC				
Prior	51,392			30,911
Current				
Total	51,392	-	-	30,911
Related Party 3 -				
Prior				
Current				
Total	-	-	-	-
Related Party 4				
Prior				
Current				
Total	-	-	-	-
Total	**761,683**	**-**	**-**	**741,202**

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

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. [X] 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	See							5
6	Suppl.				25,772			6
7	TOTAL				$ 25,772 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 12,387 Description: See Supplemental Schedule
(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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Alloc. - SAK Management Services, LLC	25,772
Total	25,772

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Item Rented	Amount
Xerox Financial Services, LLC	Copier	10,225
Alloc. - SAK Management Services, LLC		2,162
Total		12,387

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

   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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	39 - 03	hrs	$		$ 422,280	$		$ 422,280	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			359,367			359,367	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			73,909			73,909	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				199,147		199,147	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					1,532		1,532	12
13	Other (specify): See Supplemental	39 - 03				30,808			30,808	13
14	TOTAL			$		$ 886,364	$ 200,679		$ 1,087,043	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

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	1,532	
Radiology		2,122
Laboratory		28,686
Total	1,532	30,808

STATE OF ILLINOIS

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 64,740	$ 186,880	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 603,124)	2,827,577	2,827,577	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule		459,943	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,892,317	$ 3,474,400	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,000	13
14	Buildings, at Historical Cost		9,761,227	14
15	Leasehold Improvements, at Historical Cost	137,699	137,699	15
16	Equipment, at Historical Cost	263,928	974,219	16
17	Accumulated Depreciation (book methods)	(302,240)	(2,436,325)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		205,590	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 99,387	$ 8,797,410	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,991,704	$ 12,271,810	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,822,592	$ 1,912,328	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,557	268,557	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,200	5,200	31
32	Accrued Real Estate Taxes(Sch.IX-B)		85,025	32
33	Accrued Interest Payable		50,433	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	2,545,986	2,545,986	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,642,335	$ 4,867,529	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,240,626	1,240,626	39
40	Mortgage Payable		11,528,367	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,240,626	$ 12,768,993	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,882,961	$ 17,636,522	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,891,257)	$ (5,364,712)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,991,704	$ 12,271,810	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Escrows		459,943
Total	-	459,943
Line 23 - Other Long Term Assets		
Financing Costs (Net of Amortization)		205,590
	-	
Total	-	205,590
Line 36 - Other Current Liabilities		
Due to Affiliated Entities	2,545,986	2,545,986
Total	2,545,986	2,545,986
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,146,280)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,146,280)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(634,017)	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	(110,960)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (744,977)	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)**	$ (2,891,257)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 8,281,418	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,281,418	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	704	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)**	$ 704	23
	D. Non-Operating Revenue		
24	Contributions	300	24
25	Interest and Other Investment Income***	1,020	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,320	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,535	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,535	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,285,977	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,463,650	31
32	Health Care	2,898,621	32
33	General Administration	1,897,139	33
	B. Capital Expense		
34	Ownership	1,220,248	34
	C. Ancillary Expense		
35	Special Cost Centers	1,155,328	35
36	Provider Participation Fee	285,008	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,919,994	40
41	**Income before Income Taxes (line 30 minus line 40)****	(634,017)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (634,017)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,138,848	44
45	Private Pay - Net Inpatient Revenue	1,243,325	45
46	Medicare - Net Inpatient Revenue	2,369,968	46
47	Other-(specify) Insurance - Net Inpatient Revenue	529,277	47
48	Other-(specify) Veterans and Hospice - Net Inpatient Revenue		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,281,418	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' COMPILATION REPORT

St. Anthony's Nursing & Rehab Center, LLC
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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Medical Records Income	341	341
Vending Commissions	1,270	
Other Income	925	925
Total	2,536	1,266

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,152	2,248	$ 96,434	$ 42.90	1
2	Assistant Director of Nursing	2,056	2,096	59,427	28.35	2
3	Registered Nurses	10,255	10,790	279,934	25.94	3
4	Licensed Practical Nurses	33,866	35,551	765,688	21.54	4
5	CNAs & Orderlies	101,655	106,044	1,164,052	10.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,436	6,756	70,358	10.41	10
11	Social Service Workers	1,944	2,080	34,228	16.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,780	28,151	266,150	9.45	15
16	Dishwashers					16
17	Maintenance Workers	7,769	8,181	114,774	14.03	17
18	Housekeepers	17,950	18,592	160,679	8.64	18
19	Laundry	6,554	7,193	63,026	8.76	19
20	Administrator	2,067	2,155	82,017	38.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,549	6,035	98,008	16.24	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) See Supplemental	8,503	9,108	188,917	20.74	33
34	TOTAL (lines 1 - 33)	233,536	244,980	$ 3,443,692 *	$ 14.06	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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		$ 10,508	01 - 03	35
36	Medical Director		26,025	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,351	10 - 03	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		2,097	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 47,981		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

St. Anthony's Nursing & Rehab Center, LLC
Medicaid Cost Report
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Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Security (Line 7)	3,004	3,149	26,088
MDS Coordinator (Line 10)	3,563	3,879	97,929
Marketing (Line 43)	1,936	2,080	64,900
Total	8,503	9,108	188,917

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Alumbaugh	Administrator	0	$ 11,653
Cindy Brill	Administrator	0	56,317
Angela Ince	Administrator	0	777
Dustin McDonald	Administrator	0	13,270
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,017

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SAK Management Services, LLC	Management Fees	$ 452,778
SAK Management Services, LLC	Administrative Consultant	120,205
SAK Management Services, LLC	Data Processing	
SAK Management Services, LLC	Legal	
Plante & Moran, PLLC	Accounting	16,502
Personnel Planners, Inc.	Unemployment Consultant	2,863
Polsinelli Shughart, PC	Legal	54,306
Dentons US, LLP	Legal	11,187
Stephen N Sher	Legal	4,660
Stone, Pogrund & Korey, LLC	Legal	4,945
Aronberg, Goldgehn, Davis Ga	Legal	150
See Supplemental Schedule	See Supplemental Schedule	63,237
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 730,832

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,858
Unemployment Compensation Insurance	55,896
FICA Taxes	255,097
Employee Health Insurance	71,985
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	6,419
TOTAL (agree to Schedule V, line 22, col.8)	$ 483,255

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	13,380
Health Care Worker Background Check	6,490
(Indicate # of checks performed)	
Patient Background Checks	2,960
Dues and Subscriptions	24,726
Licenses	2,540
Advertising and Promotion	
Alloc. - SAK Management Services, LLC	4,687
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,773

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	165
Alloc. - SAK Management Services, LLC	1,320
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,485

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

St. Anthony's Nursing & Rehab Center, LLC
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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Description of Services	Total
Future Wave Tech, Inc.	Data Processing	4,421
Wescom Solutions, Inc.	Data Processing	18,851
Compu Solutions, Inc.	Data Processing	12,623
Emdeon Business Services	Data Processing	239
HDSI	Data Processing	3,438
Mainline Communications	Data Processing	6,971
LTC Solutions, Inc.	Data Processing	1,800
COTG	Data Processing	415
Proliant	Data Processing	4,842
Quickbooks	Data Processing	3,114
Other	Data Processing	6,525
Sub-Total		63,237

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Total	Non-Allowable Amount
Polsinelli Shughart, PC	01/21/15	Non-Allowable (Prior Period)	96	96
Polsinelli Shughart, PC	01/21/15	Non-Allowable (Prior Period)	1,768	1,768
Aronberg, Goldgehn, Davis & Gamisa	02/13/15	Annual Report Filing	150	
Polsinelli Shughart, PC	04/28/15	IDPH Survey / Plan of Correction	1,768	
Polsinelli Shughart, PC	04/28/15	IDPH Survey / Plan of Correction	96	
Polsinelli Shughart, PC	04/28/15	IDPH Survey / Plan of Correction	175	
Polsinelli Shughart, PC	04/28/15	IDPH Survey / Plan of Correction	1,873	
Stephen N. Sher	04/30/15	Loan Agreement Review	2,625	
Dentons US, LLP	05/15/15	Loan Agreement Review	3,904	
Stone, Pogrund, Korey, LLC	05/28/15	Non-Allowable (Collections)	804	804
Polsinelli Shughart, PC	05/29/15	IDPH Survey / Plan of Correction	7,303	
Polsinelli Shughart, PC	06/22/15	IDPH Survey / Plan of Correction	10,414	
Stone, Pogrund, Korey, LLC	06/30/15	Non-Allowable (Collections)	1,601	1,601
Stone, Pogrund, Korey, LLC	08/01/15	Non-Allowable (Collections)	220	220
Polsinelli Shughart, PC	09/01/15	IDPH Survey / Plan of Correction	6,617	
Polsinelli Shughart, PC	09/01/15	IDPH Survey / Plan of Correction	3,112	
Polsinelli Shughart, PC	09/18/15	IDPH Survey / Plan of Correction	210	
Polsinelli Shughart, PC	10/12/15	IDPH Survey / Plan of Correction	2,935	
Stone, Pogrund, Korey, LLC	10/31/15	Non-Allowable (Collections)	913	913
Stephen N. Sher	11/06/15	Loan Agreement Review	2,035	
Dentons US, LLP	11/20/15	Loan Agreement Review	3,213	
Polsinelli Shughart, PC	11/24/15	IDPH Survey / Plan of Correction	17,940	
Stone, Pogrund, Korey, LLC	12/01/15	Non-Allowable (Collections)	1,407	1,407
Dentons US, LLP	12/30/15	Loan Agreement Review	2,670	
Dentons US, LLP	12/30/15	Loan Agreement Review	1,400	
Sub-Total			75,246	6,809

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. **ICLTC = $24,001**

(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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,871** Line **10 - 02**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **285,008**
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. $ _____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **0**

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