FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0039636

Facility Name: Cahokia Nursing & Rehab Ctr

Address: 2 Annable Court (Number) Cahokia (City) 62206 (Zip Code)

County: St. Clair

Telephone Number: (618) 332-0114 **Fax #** (618) 332-1043

HFS ID Number:

Date of Initial License for Current Owners: 06/01/1994

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 01/01/2016 to 12/31/2016 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)
(Firm Name & Address) RSM US 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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,361	7	3,719	7,087	8
9	SNF/PED					9
10	ICF	12,143	882	9,711	22,736	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,504	889	13,430	29,823	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.32%

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 06/01/94

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 512

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	238,011	25,379	5,104	268,494		268,494		268,494			1
2	Food Purchase		232,513		232,513		232,513	(48,000)	184,513			2
3	Housekeeping	191,082	46,817		237,899		237,899	63	237,962			3
4	Laundry	71,137	14,235		85,372		85,372		85,372			4
5	Heat and Other Utilities			90,766	90,766		90,766	1,007	91,773			5
6	Maintenance	65,939	13,201	889	80,029		80,029	2,323	82,352			6
7	Other (specify):*											7
8	TOTAL General Services	566,169	332,145	96,759	995,073		995,073	(44,607)	950,466			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,834,402	62,664	6,436	1,903,502		1,903,502	16,295	1,919,797			10
10a	Therapy	84,409			84,409		84,409		84,409			10a
11	Activities	81,885	7,552		89,437		89,437		89,437			11
12	Social Services	40,678			40,678		40,678		40,678			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,041,374	70,216	15,436	2,127,026		2,127,026	16,295	2,143,321			16
	C. General Administration											
17	Administrative	149,231		130,000	279,231		279,231	(96,461)	182,770			17
18	Directors Fees											18
19	Professional Services			96,448	96,448		96,448	7,841	104,289			19
20	Dues, Fees, Subscriptions & Promotions			33,859	33,859		33,859	(5,258)	28,601			20
21	Clerical & General Office Expenses	631,259		78,182	709,441		709,441	5,771	715,212			21
22	Employee Benefits & Payroll Taxes			414,639	414,639		414,639	28,094	442,733			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,694	2,694		2,694	195	2,889			24
25	Other Admin. Staff Transportation			5,599	5,599		5,599	2,175	7,774			25
26	Insurance-Prop.Liab.Malpractice			145,387	145,387		145,387	14,538	159,925			26
27	Other (specify):* Mgmt Alloc Benefits							9,034	9,034			27
28	TOTAL General Administration	780,490		906,808	1,687,298		1,687,298	(34,071)	1,653,227			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,388,033	402,361	1,019,003	4,809,397		4,809,397	(62,383)	4,747,014			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 Cahokia Nursing & Rehab Ctr #0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			101,849	101,849		101,849	54,577	156,426			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,608	12,608		12,608	141,936	154,544			32
33	Real Estate Taxes			16,121	16,121		16,121	138,048	154,169			33
34	Rent-Facility & Grounds			432,000	432,000		432,000	(432,000)				34
35	Rent-Equipment & Vehicles			7,191	7,191		7,191	943	8,134			35
36	Other (specify):* Mortgage Insurance							18,307	18,307			36
37	**TOTAL Ownership**			569,769	569,769		569,769	(78,189)	491,580			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,933	517,983	568,916		568,916		568,916			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			279,073	279,073		279,073		279,073			42
43	Other (specify):* Non-Allowable Cos			19,366	19,366		19,366	(19,366)				43
44	**TOTAL Special Cost Centers**		50,933	816,422	867,355		867,355	(19,366)	847,989			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,388,033	453,294	2,405,194	6,246,521		6,246,521	(159,938)	6,086,583			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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(71,703)	30		9
10	Interest and Other Investment Income	(4,269)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(317)	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				18
19	Entertainment				19
20	Contributions	(650)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,455)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,200)	43		24
25	Fund Raising, Advertising and Promotional	(665)	43		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 Page 5A	(102,464)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (182,723)		$	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)	22,785		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 22,785		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (159,938)		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

Cahokia Nursing & Rehab Ctr

ID# 0039636

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (3,547)	43	1
2	X Ray Expense Med A	(2,560)	43	2
3	Managed Care Cost	(10,427)	43	3
4	Disallow lobbying expense	(5,346)	20	4
5	Offset miscellaneous income	(64,214)	21	5
6	Real Estate Tax	(16,370)	33	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**	(102,464)		49

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$	Cahokia Building LLC	100%	$ 8,325	$ 8,325	1
2	V	26	Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100%	12,962	12,962	2
3	V	30	Depreciation		Cahokia Building LLC	100%	124,351	124,351	3
4	V	32	Interest Income	217	Cahokia Building LLC	100%		(217)	4
5	V	32	Interest		Cahokia Building LLC	100%	145,304	145,304	5
6	V	32	Amortization		Cahokia Building LLC	100%	1,118	1,118	6
7	V	33	Real Estate Tax		Cahokia Building LLC	100%	151,432	151,432	7
8	V	34	Rent	432,000	Cahokia Building LLC	100%		(432,000)	8
9	V	36	Mortgage Insurance		Cahokia Building LLC	100%	18,307	18,307	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 432,217			$ 461,799	$ * 29,582	14

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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%	$ 295	$ 295	15
16	V	3	Housekeeping		SW Financial Services Company	100%	63	63	16
17	V	5	Utilities		SW Financial Services Company	100%	1,007	1,007	17
18	V	6	Maintenance		SW Financial Services Company	100%	2,323	2,323	18
19	V	17	Administrative	130,000	SW Financial Services Company	100%	33,539	(96,461)	19
20	V	19	Professional Services		SW Financial Services Company	100%	971	971	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100%	88	88	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100%	69,985	69,985	22
23	V	24	Travel & Seminar		SW Financial Services Company	100%	195	195	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100%	2,175	2,175	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100%	1,576	1,576	25
26	V	27	Management Allocated Benefits		SW Financial Services Company	100%	9,034	9,034	26
27	V	30	Depreciation		SW Financial Services Company	100%	1,929	1,929	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100%	2,986	2,986	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100%	943	943	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			$ 130,000			$ 127,109	$ * (2,891)	39

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 39,303	S & E Medical Supply Co.	95%	$ 19,102	$ (20,201)	15
16	V	10	Medical Supplies	2,000	S & E Medical Supply Co.	95%	18,295	16,295	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			$ 41,303			$ 37,397	$ * (3,906)	39

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			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			Linn Living & Rehabilitation Center	Linn, MO	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					FOM Property LLC	Franklin Grove	Real Estate	21
22								22
23					Oregon Property LLC	Oregon	Real Estate	23
24					Praire Crossing	Shabbona	Real Estate	24
25					Property LLC			25
26								26
27					Tower Hill Property L	South Elgin	Real Estate	27
28								28
29								29
30								30

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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					Linn Property LLC	Linn, MO	Real Estate	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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	0.00	See Schedule 7A	4.5	0.10	Salary	$ 18,500	L17, C7	1
2											2
3											3
4											4
5											5
6			Note: Mr. Wolfe works in excess of 40 hours per week.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,500		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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 Co.
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	717,580	13	$ 3,854	$	54,900	$ 295	1
2	3	Housekeeping	Bed Days Available	717,580	13	817		54,900	63	2
3	5	Utilities	Bed Days Available	717,580	13	13,161		54,900	1,007	3
4	6	Maintenance	Bed Days Available	717,580	13	30,368		54,900	2,323	4
5	19	Professional Services-Legal	Bed Days Available	717,580	13	46		54,900	4	5
6	19	Professional Services-Other	Bed Days Available	717,580	13	12,642		54,900	967	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	717,580	13	1,154		54,900	88	7
8	21	Clerical & General Office Expense	Bed Days Available	717,580	13	748,843	748,843	54,900	57,292	8
9	21	Clerical & General Office Expense	Bed Days Available	717,580	13	165,903		54,900	12,693	9
10	24	Travel & Seminar	Bed Days Available	717,580	13	2,553		54,900	195	10
11	25	Other Admin. Staff Transportion	Bed Days Available	717,580	13	28,429		54,900	2,175	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	717,580	13	20,601		54,900	1,576	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	717,580	13	118,085		54,900	9,034	13
14	33	Real Estate Taxes	Bed Days Available	717,580	13	39,025		54,900	2,986	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	717,580	13	12,328		54,900	943	15
16										16
17	17	Administrative - Salary	Avg Hours Worked	45	13	185,000	185,000	5	18,500	17
18	17	Administrative - Salary	Avg Hours Worked	45	13	150,387	150,387	5	15,039	18
19										19
20										20
21	30	Depreciation	Direct Cost	25,216					1,929	21
22										22
23										23
24										24
25	TOTALS					$ 1,533,196	$ 1,084,230		$ 127,109	25

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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: ( )

	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			$	$		$ 19,102	1
2	10	Medical Supplies	Direct Cost						18,295	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					$	$		$ 37,397	25

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	23524	11/27/01	$ 3,961,000	$ 3,618,609	12/1/36	0.0635	$ 145,304	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit	Interest Only	4/15/2016	1,000,000	731,000	5/15/2017	0.0475	12,608	6
7												7
8												8
9	TOTAL Facility Related				$23,524.00		$ 4,961,000	$ 4,349,609			$ 157,912	9
	B. Non-Facility Related*											
10												10
11								Amortization of Mortgage Costs			1,118	11
12								Interest Income			(4,486)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,368)	14
15	TOTALS (line 9+line14)						$ 4,961,000	$ 4,349,609			$ 154,544	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 18,307 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 Cahokia Nursing & Rehab Ctr # 0039636 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 142,300	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.)	2015	$ 144,583	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,283	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 148,900	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.)	Alloc. Fr. Mgmt Co. 2,986	$	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.		$ 154,169	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	115,192	8
	2012	102,970	9
	2013	130,106	10
	2014	140,494	11
	2015	144,583	12

Tax Accrual = 144,583 * 1.03% = 148,900

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cahokia Nursing & Rehabilitation Center, Inc. COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039636

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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-02.0-310-055	Long Term Care Property	$ 142,186.26	$ 142,186.26
2.	06-02.0-310-054	Long Term Care Property	$ 2,396.60	$ 2,396.60
3.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 40,533.35	$ 2,986.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 185,116.21	$ 147,568.86

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 230,000	1
2	Office Space for Resident Care Em		2006	15000	2
3	TOTALS			$ 245,000	3

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		$ 2,928,441	$	15-40	$ 68,691	$ 68,691	$ 1,128,394	4
5			2006		55,818	2,030	40	1,431	(599)	15,027	5
6										-	6
7											7
8	Allocated from Management Co.		1995		31,883			911	911	19,727	8
	Improvement Type**										
9	Various			1994	17,859	268	20		(268)	17,859	9
10	Various			1995	33,623	271	20		(271)	33,623	10
11	Various			1996	2,178	56	20	35	(21)	2,178	11
12	Various			1997	9,423		20	471	471	9,189	12
13	Various			1998	4,800		20	240	240	4,440	13
14	Various			1999	16,266	93	20	813	720	14,416	14
15	Air Handler			2000	1,516		5			1,516	15
16	Alarm System			2001	1,908		5			1,908	16
17	Blind			2001	1,212		5			1,212	17
18	Air Handler			2001	1,317		20	66	66	1,022	18
19	Fan Motor			2001	1,123		20	56	56	846	19
20	Drywall-Dining Room			2002	10,650	184	10		(184)	10,650	20
21	Door			2002	9,860	184	20	493	309	6,943	21
22	Air Conditioner			2002	1,198		7			1,198	22
23	Air Conditioner			2002	1,582		7			1,582	23
24	Air Conditioners			2002	4,284		7			4,284	24
25	Compressor Air Maxi			2002	1,269		7			1,269	25
26	Roof - New			2003	97,996		20	4,900	4,900	67,374	26
27	Nursing Station			2003	35,060		20	1,753	1,753	23,373	27
28	Nursing Station			2003	28,692		20	1,435	1,435	20,326	28
29	Nursing Station			2003	6,368		20	318	318	4,164	29
30	Replace Accelerator			2003	968		20	48	48	675	30
31	Sprinkler System			2004	3,610	131	20	181	50	2,259	31
32	Smoke shelter			2004	6,041	220	20	302	82	3,775	32
33	Security System			2005	11,166	406	20	558	152	6,418	33
34	Condensing Unit - 5 Ton			2005	1,959		20	98	98	1,127	34
35	Cabinets and countertops			2005	110,923	4,011	20	5,546	1,535	63,780	35
36	Air Handler			2005	1,549		20	78		894	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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Asphalt Parking Lot	2005	$ 5,570	$ 329	20	$ 279	$ (51)	$ 3,204	37
38	A/C Unit 2 Tons	2005	1,092	40	20	55	15	628	38
39	Reframe & drywall 3 windows	2005	4,200	153	20	210	57	2,415	39
40	Carpet & Vinyl Floor	2005	4,390		20	220	220	2,525	40
41	Sprinkler System - new pipe	2005	1,463		20	73	73	841	41
42	Door Alarms	2005	3,587	130	20	179	49	2,061	42
43	Wallpaper	2005	17,835		20	892	892	10,256	43
44	Painting and Wallcovering	2005	29,600		20	1,480	1,480	17,020	44
45	6 Doors	2005	1,926		20	96	96	1,107	45
46	Plaster Ceiling	2005	10,392	378	20	520	142	5,976	46
47	Vinyl Flooring	2005	4,878	177	20	244	67	2,805	47
48	Duct Heater	2006	1,195		20	60	60	628	48
49	Kitchen Garbage Disposal	2006	1,467		20	73	73	769	49
50	Copper Pipe & Concrete	2006	3,722		20	186	186	1,953	50
51	Fence	2006	6,061	358	20	303	(55)	3,182	51
52	Shower Remodel - Hall 400	2006	21,570	785	20	1,079	294	11,325	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	5,120	53
54	Shower Remodel - Hall 200	2006	21,570	785	20	1,079	294	11,325	54
55	Shower Remodel - Hall 500	2006	21,570	785	20	1,079	294	11,325	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	10,279	56
57	Front Entrance	2006	2,150	78	20	108	30	1,130	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	1,764	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	907	59
60	Compressor-Walk In Freezer	2006	1,784		20	89	89	936	60
61	Air Conditioners (5)	2006	2,146		10	106	106	2,146	61
62	Air Conditioners (6)	2006	2,576		20	129	129	1,353	62
63	Phone System	2006	1,658		20	83	83	871	63
64	Remove & reinstall 6 dry pendents	2007	3,039	111	20	152	41	1,444	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	3,563	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	84	(32)	1,203	66
67	New Window Glass	2007	3,562		20	178	178	1,691	67
68	Paving, Parking Lot & Driveway	2007	32,275	1,773	20	113	(1,661)	9,326	68
69	Handrails	2007	2,980		20	149	149	1,416	69
70	TOTAL (lines 4 thru 69)		$ 3,699,879	$ 15,376		$ 99,814	$ 84,360	$ 1,603,943	70

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		$ 3,699,879	$ 15,376		$ 99,814	$ 84,438	$ 1,603,943	1
2	Fire Damper and Roof Vent	2007	5,114	103	20	256	153	2,430	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790	83	20	440	357	4,176	3
4	Walk In Freezer Door	2008	2,316	84	20	116	32	1,100	4
5	Replace 4 Inch Main	2008	3,158	115	20	158	43	1,343	5
6	Sprinkler heads for alarm	2008	29,310	1,066	20	1,466	400	12,458	6
7	Sign	2009	2,685		20	134	134	1,141	7
8	Hot Water Heater	2009	5,182	185	20	259	74	1,943	8
9	Vinyl Flooring	2009	14,512		20	726	726	5,445	9
10	Hot Water Heater	2010	5,094		20	255	255	1,912	10
11	Valves	2011	3,310	120	20	166	46	1,076	11
12	100 gallon hot water heater	2011	33,232	1,208	20	1,662	454	9,139	12
13	Security system - Phase 1 & 2	2011	21,394		20	1,070	1,070	5,884	13
14									14
15	Patio	2012	5,848		20	455	455	2,046	15
16	Gazebo	2012	19,098		20	637	637	2,864	16
17									17
18	Duct Heater	2013	3,213		20	161	161	562	18
19	Two Water Heaters & replace 2" main shut off valve &	2013	15,085		20	754	754	2,640	19
20	1 1/2" swing check valve								20
21									21
22	A/C Units	2013	4,380		20	219	219	767	22
23	-Removal of existing outdoor A/C unit								23
24	-Install a new 1 1/2 ton A/C unit and a 4 ton A/C unit								24
25	-Install A new trunk line and insulate with duct liner								25
26	-Install A new liquid line filter drier & pressure test								26
27									27
28	Parking Lot Improvement	2013	54,724		20	2,736	2,736	9,577	28
29	-Update the parking lot by milling butt joints,								29
30	patching failed areas, cleaning, applying a primer coat								30
31	-Installed 1.5' Hot Mix Asphalt Overlay								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,936,323	$ 18,340		$ 111,481	$ 93,141	$ 1,670,446	34

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		$ 3,936,323	$ 18,340		$ 111,481	$ 93,141	$ 1,670,446	1
2	Basement Remodel	2013	30,088		20	1,504	1,504	5,265	2
3	-Frame walls and exterior concrete								3
4	-Replace electrical can lights and recepticals								4
5	-Add heat register in office								5
6	-Install commercial carpet on floor								6
7	-Replace drywall walls and ceilings								7
8	-Replace 4 windows								8
9	-Add sink and new plumbing								9
10	-Crack in wall repair								10
11									11
12	Fire alarm replacement	2013	17,758		20	888	888	3,108	12
13									13
14	Asphalt and sealcoating - Driveway and 2 Walkways	2014	2,750	116	20	138	22	413	14
15	Remove and replace patio	2014	17,831		20	892	892	2,675	15
16	New exhaust fan and installation on roof	2014	3,210	117	20	161	44	482	16
17	Replace transfer switches - Generator	2014	4,727	172	20	236	64	709	17
18	3 ton air handler & 5 ton air handler & ductwork-Mech Room	2014	3,100		20	155	155	465	18
19	Replace new PVC drain, toilet, sink, sump pump-Office	2014	2,647	96	20	132	36	397	19
20									20
21	Replace original ductwork - Several areas of facility	2015	7,029		20	351	351	527	21
22	Remove concrete floor to replace damaged pipes with PVC	2015	3,000		20	150	150	225	22
23	Replace heat packages in offices, nurses stations, D Hall 400 & 600	2015	3,074		20	154	154	231	23
24	Wanderguard transmitter	2015	2,686		20	134	134	201	24
25	5 PTAC heaters	2015	2,869		20	143	143	215	25
26									26
27	Asphalt sidewalk - Behind Bldg & South Side	2016	12,882	6,763	20	322	(6,441)	322	27
28	Replaced 4" main - 100 Hall	2016	4,689	121	20	117	(4)	117	28
29	Hot water heater - 400 Hall in rear mechanical room	2016	7,775	177	20	194	17	194	29
30	Dry pendant head - 500 Hall	2016	9,190	181	20	230	49	230	30
31	Freezer condenser unit - Kitchen Walk-In freezer	2016	4,154	82	20	104	22	104	31
32	AC unit - Electrical Room	2016	5,476	108	20	137	29	137	32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,081,258	$ 26,273		$ 117,623	$ 91,350	$ 1,686,462	34

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 12C, Carried Forward		$ 4,081,258	$ 26,273		$ 117,623	$ 91,350	$ 1,686,462	1
2	Hot water heater - 100 Hall by nrs stn & frt mech rm (3 total)	2016	7,307	78	20	183	105	183	2
3	Replaced AC unit compressors - Library unit	2016	3,862	41	20	97	56	97	3
4	Hot water heater - 100 Hall by nrs stn & frt mech rm (3 total)	2016	6,000	27	20	150	123	150	4
5	10 PTAC Units - throughout building	2016	5,578	3,347	5	558	(2,789)	558	5
6	6 PTAC Units - throughout building	2016	3,819	2,292	5	382	(1,910)	382	6
7	Replaced ducts, pipes & heat packages - throughout building	2016	13,104		15	437	437	437	7
8									8
9	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	3,568		20			3,568	9
10	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	594		20	11	11	592	10
11	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	689		20			689	11
12	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	589		20	29	29	552	12
13	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,635		20	82	82	1,397	13
14	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	3,383		20	169	169	1,945	14
15	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,915		20	96	96	910	15
16	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	3,998		20	200	200	1,499	16
17	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	2,135		20	107	107	374	17
18	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	2,153		20	108	108	269	18
19	Allocated from SW Financial Services Co. - Leasehold Improveme	2015	442		20	29	29	44	19
20									20
21									21
22	To adjust to book depreciation								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)		$ 4,142,029	$ 32,058		$ 120,260	$ 88,202	$ 1,700,107	34

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 848,591	$ 4,661	$ 22,499	$ 17,838	5-10	$ 645,855	71
72	Current Year Purchases	102,390	61,436	10,239	(51,197)	5	10,239	72
73	Fully Depreciated Assets	165,265			-		165,265	73
74	Allocated from Mgmt Co	10,479		187	187		8,984	74
75	TOTALS	$ 1,126,725	$ 66,097	$ 32,925	$ (33,172)		$ 830,343	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 Use	2014 Chrysler Town & Country	2014	$ 32,408	$ 3,694	$ 3,241	$ (453)	5	$ 12,963	76
77					-	-	-			77
78	Allocated from Mgmt Co	2010 Infinity	2010	5,730	-	-	-	5	5,730	78
79					-	-	-			79
80	TOTALS			$ 38,138	$ 3,694	$ 3,241	$ (453)		$ 18,693	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)	$ 5,551,892	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 101,849	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 156,426	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 54,577	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,549,143	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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,191 Description: Medical Equipment $7,191
(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.		$	$ 943	17
18					18
19					19
20					20
21	TOTAL		$	$ 943	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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	$	3,133	$ 225,545	$	3,133	$ 225,545	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,079	99,784		2,079	99,784	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		3,010	192,654		3,010	192,654	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				42,846		42,846	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					8,087		8,087	12
13	Other (specify):									13
14	TOTAL			$	8,222	$ 517,983	$ 50,933	8,222	$ 568,916	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 Cahokia Nursing & Rehab Ctr **#** 0039636 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 18,592	$ 200,668	1
2	Cash-Patient Deposits	24,241	24,241	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,000))	2,176,663	2,176,663	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,767	30,222	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	63,166	342,918	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,300,429	$ 2,774,712	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	3,016,142	14
15	Leasehold Improvements, at Historical Cost	716,333	1,125,887	15
16	Equipment, at Historical Cost	456,641	1,164,863	16
17	Accumulated Depreciation (book methods)	(742,967)	(2,549,143)	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		110,025	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 500,825	$ 3,112,774	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,801,254	$ 5,887,486	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,042	$ 135,822	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,441	26,441	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,849	143,849	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,021	16,021	31
32	Accrued Real Estate Taxes(Sch.IX-B)		148,900	32
33	Accrued Interest Payable		5,160	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	429,565	429,565	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 743,918	$ 905,758	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	731,000	4,349,609	39
40	Mortgage Payable			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)**	$ 731,000	$ 4,349,609	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,474,918	$ 5,255,367	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,326,336	$ 632,119	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,801,254	$ 5,887,486	48

***(See instructions.)**

Facility Name: **Cahokia Nursing & Rehab Ctr**
IDPH License ID Number: **0039636**
Fiscal Year End: **12/31/2016**

Schedule 17A

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

Description	Operating	After Consolidation
NH RE Replacement Reserve	-	212,743
NH RE Escrow Real Estate Tax	-	67,009
Due From State - Interest	20,080	20,080
NH Employee Payroll Advance	1,716	1,716
NH Short term Loan Exchange	41,370	41,370
Total - Line 9	**63,166**	**342,918**

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

Description	Operating	After Consolidation
NH Construction in Progress	-	75,000
NH RE Capitalized Costs	-	35,025
Total - Line 9	**-**	**110,025**

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

Description	Operating	After Consolidation
NH Due From State	119,690	119,690
NH Due to State per audit	27,610	27,610
NH Reimbursement Due	(58,306)	(58,306)
NH Insurance Premiums Payable	1,760	1,760
Accrued Expenses	249,638	249,638
NH Due To/From Cahokia Property	75,000	75,000
NH Due To/From Vacant Cahokia Property	14,173	14,173
Total - Line 36	**429,565**	**429,565**

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,078,014	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,078,014	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(751,677)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (751,678)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,326,336	24 *

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

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 4,514,178	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,514,178	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	587,101	6
7	Oxygen	9,705	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 596,806	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***	4,269	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,269	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Business Interruption Income	375,498	28
28a	Miscellaneous Income	4,093	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 379,591	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,494,844	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	995,073	31
32	Health Care	2,127,026	32
33	General Administration	1,687,298	33
	B. Capital Expense		
34	Ownership	569,769	34
	C. Ancillary Expense		
35	Special Cost Centers	588,282	35
36	Provider Participation Fee	279,073	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,246,521	40
41	**Income before Income Taxes (line 30 minus line 40)****	(751,677)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (751,677)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,844,933	44
45	Private Pay - Net Inpatient Revenue	80,291	45
46	Medicare - Net Inpatient Revenue	255,028	46
47	Other-(specify) Hospice	116,247	47
48	Other-(specify) VA	217,679	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,514,178	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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	1,659	1,659	$ 58,420	$ 35.21	1
2	Assistant Director of Nursing	1,424	1,456	42,692	29.32	2
3	Registered Nurses	6,218	6,399	178,041	27.82	3
4	Licensed Practical Nurses	21,269	22,751	512,200	22.51	4
5	CNAs & Orderlies	79,756	86,141	1,043,049	12.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,414	5,279	84,409	15.99	8
9	Activity Director					9
10	Activity Assistants	5,668	6,237	81,885	13.13	10
11	Social Service Workers	2,913	3,080	40,678	13.21	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	44,595	21.44	13
14	Head Cook	8,467	9,028	94,776	10.50	14
15	Cook Helpers/Assistants	8,262	8,862	98,640	11.13	15
16	Dishwashers					16
17	Maintenance Workers	4,276	4,614	65,939	14.29	17
18	Housekeepers	17,790	19,446	191,082	9.83	18
19	Laundry	7,118	7,837	71,137	9.08	19
20	Administrator	2,728	2,985	149,231	49.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	12,959	13,851	403,665	29.14	23
24	Clerical	9,814	10,541	227,594	21.59	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)	196,735	212,246	$ 3,388,033 *	$ 15.96	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	$ 5,104	L1, C3	35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,436	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,540		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 Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Danille Young	Administrator	0	$ 52,151
Cheryl Linhorst	Administrator	0	24,158
Robin Suydam	General Manager	0	72,922
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 149,231

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 10,000
Management Fees	120,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 130,000

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLP	Accounting	$ 21,932
Helper, Broom, Macdonald, Hebrank	Legal	9,164
Polsinelli Shughart	Legal	61,127
Resident Receivables	Legal	625
Unemployment Consultants	U/E Consultant	3,600
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 96,448

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,002
Unemployment Compensation Insurance	68,422
FICA Taxes	257,827
Employee Health Insurance	40,148
Employee Meals	28,094
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	1,240
TOTAL (agree to Schedule V, line 22, col.8)	$ 442,733

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	$ 4,940
Advertising: Employee Recruitment	
Health Care Worker Background Check	2,000
(Indicate # of checks performed 167)	
Patient Background Checks 322	3,223
Miscellaneous Inspections & Licenses	4,438
Miscellaneous Dues & Permits	3,058
Illinois Council on Long Term Care	16,200
Allocated from Management Co.	88
Less: Public Relations Expense	(5,346)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,601

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,694
Allocated from Mgmt Co	195
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,889

**See instructions.

Facility Name: **Cahokia Nursing & Rehab Ctr**
IDPH License ID Number: **0039636**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Professional Fees from Page 20 Section C		96,448
	Total (agree to Schedule V, line 19, column 3)	96,448
Allocated from Management Company	Legal Fees	4
Allocated from Management Company	Professional Services	967
Allocated from Real Estate Entity	Professional Services	8,325
Less: Non-Allowable Legal Fees		(1,455)
	Total (agree to Schedule V, line 19, column 8)	104,289

Facility Name & ID Number Cahokia Nursing & Rehab Ctr # 0039636 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care-$16,200**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,559** 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. $ **279,073**
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. $ **28,094** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
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? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees