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: 0039644

Facility Name: Caseyville Nrsg & Rehab Ctr

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

County: St Clair

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

HFS ID Number:

Date of Initial License for Current Owners: 6/01/94

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 Caseyville Nrsg & Rehab Ctr # 0039644 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	1,793	778	2,392	4,963	8
9	SNF/PED					9
10	ICF	21,557	4,727	10,793	37,077	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,350	5,505	13,185	42,040	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.58%

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 2,338

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 Caseyville Nrsg & Rehab Ctr # 0039644 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	280,632	30,789	6,018	317,439		317,439		317,439			1
2	Food Purchase		294,108		294,108		294,108	(2,911)	291,197			2
3	Housekeeping	139,961	48,229		188,190		188,190	63	188,253			3
4	Laundry	125,502	20,969		146,471		146,471		146,471			4
5	Heat and Other Utilities			189,218	189,218		189,218	1,007	190,225			5
6	Maintenance	142,968	152,000	8,503	303,471		303,471	2,323	305,794			6
7	Other (specify):*											7
8	TOTAL General Services	689,063	546,095	203,739	1,438,897		1,438,897	482	1,439,379			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,850,031	123,577	11,608	1,985,216		1,985,216	(5,808)	1,979,408			10
10a	Therapy	90,137			90,137		90,137		90,137			10a
11	Activities	81,983	12,471	1,196	95,650		95,650		95,650			11
12	Social Services	37,945			37,945		37,945		37,945			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,060,096	136,048	16,404	2,212,548		2,212,548	(5,808)	2,206,740			16
	C. General Administration											
17	Administrative	101,106		334,000	435,106		435,106	(300,461)	134,645			17
18	Directors Fees											18
19	Professional Services			71,919	71,919		71,919	8,773	80,692			19
20	Dues, Fees, Subscriptions & Promotions			26,369	26,369		26,369	(5,008)	21,361			20
21	Clerical & General Office Expenses	550,597		52,330	602,927		602,927	60,345	663,272			21
22	Employee Benefits & Payroll Taxes			402,551	402,551		402,551	5,694	408,245			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,099	4,099		4,099	195	4,294			24
25	Other Admin. Staff Transportation			24,416	24,416		24,416	2,175	26,591			25
26	Insurance-Prop.Liab.Malpractice			208,032	208,032		208,032	13,593	221,625			26
27	Other (specify):* Mgmt Alloc of Benefit							9,034	9,034			27
28	TOTAL General Administration	651,703		1,123,716	1,775,419		1,775,419	(205,660)	1,569,759			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,400,862	682,143	1,343,859	5,426,864		5,426,864	(210,986)	5,215,878			29

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr #0039644 Report Period Beginning: 01/01/2016 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			30,974	30,974		30,974	214,009	244,983			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,638	12,638		12,638	172,285	184,923			32
33	Real Estate Taxes							72,171	72,171			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)				34
35	Rent-Equipment & Vehicles			732	732		732	943	1,675			35
36	Other (specify):* Mortgage Insurance							27,679	27,679			36
37	**TOTAL Ownership**			608,344	608,344		608,344	(76,913)	531,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,389	900,745	1,006,134		1,006,134		1,006,134			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			319,158	319,158		319,158		319,158			42
43	Other (specify):* Non-Allowable Cos			65,858	65,858		65,858	(65,858)				43
44	**TOTAL Special Cost Centers**		105,389	1,285,761	1,391,150		1,391,150	(65,858)	1,325,292			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,400,862	787,532	3,237,964	7,426,358		7,426,358	(353,757)	7,072,601			45

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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	26,841	30		9
10	Interest and Other Investment Income	(43,083)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(556)	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	(244)	43		18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(353)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,444)	43		24
25	Fund Raising, Advertising and Promotional	(1,950)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,000)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(33,669)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,858)		$	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)	(265,899)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (265,899)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (353,757)		37

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

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

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

Caseyville Nrsg & Rehab Ctr

ID# 0039644

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (9,575)	43	1
2	X Ray Expense Med A	(6,261)	43	2
3	Managed Care Cost	(12,339)	43	3
4	Collections	(89)	43	4
5	Offset Miscellaneous Income	(59)	21	5
6	Lobbying Expense	(5,346)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
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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**	(33,669)		49

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 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	$	Caseyville Property LLC	100%	$ 8,155	$ 8,155	1
2	V	20	Dues, Fees, Subs. & Promotions		Caseyville Property LLC	100%	250	250	2
3	V	21	Miscellaneous Income	9,581	Caseyville Property LLC	100%		(9,581)	3
4	V	26	Insurance-Prop.Liab.Malpractice		Caseyville Property LLC	100%	12,017	12,017	4
5	V	30	Depreciation		Caseyville Property LLC	100%	185,239	185,239	5
6	V	32	Interest	213	Caseyville Property LLC	100%	205,097	204,884	6
7	V	32	Amortization		Caseyville Property LLC	100%			7
8	V	32	Debt Issuance Cost		Caseyville Property LLC	100%	10,484	10,484	8
9	V	33	Real Estate Taxes		Caseyville Property LLC	100%	69,185	69,185	9
10	V	34	Rent	564,000	Caseyville Property LLC	100%		(564,000)	10
11	V	36	Mortgage Insurance		Caseyville Property LLC	100%	27,679	27,679	11
12	V								12
13	V								13
14	Total			$ 573,794			$ 518,106	$ * (55,688)	14

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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	334,000	SW Financial Services Company	100%	33,539	(300,461)	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	Other		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			$ 334,000			$ 127,109	$ * (206,891)	39

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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	$ 23,187	S & E Medical Supply Co.	95%	$ 17,379	$ (5,808)	15
16	V	10	Medical Supplies	7,273	S & E Medical Supply Co.	95%	9,761	2,488	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			$ 30,460			$ 27,140	$ * (3,320)	39

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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 Suppo	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 LL	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					Prairie 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 Caseyville Nrsg & Rehab Ctr # 0039644 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 Caseyville Nrsg & Rehab Ctr # 0039644 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	6 Percent	7 Compensation Included in Costs for this Reporting Period** Description	7 Amount	8 Schedule V. Line & Column Reference	
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	4.5	10.00	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			See attached schedule 7A for additional compensation information.								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 Caseyville Nrsg & Rehab Ctr # 0039644 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 Company
Street Address: 7434 N. Skokie Blvd
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	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, Subs. & Promotions	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	Average Hours Worked	45	13	185,000	185,000	5	18,500	17
18	17	Administrative - Salary	Average Hours Worked	45	13	150,387	150,387	5	15,039	18
19										19
20	30	Depreciation	Direct Cost	25,216					1,929	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,533,196	$ 1,084,230		$ 127,109	25

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 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: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 17,379	1
2	10	Medical Supplies	Direct Cost						9,761	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					$	$		$ 27,140	25

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 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	38,896	11/27/01	$ 6,814,000	$ 5,467,420	12/1/36	0.0635	$ 205,097	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Member Loan	X		Working Capital	Varies	5/15/2016	1,000,000	750,000	5/15/2017	0.0500	12,638	6
7												7
8												8
9	**TOTAL Facility Related**				$38,896.00		$ 7,814,000	$ 6,217,420			$ 217,735	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(43,296)	12
13								Debt Issuance Cost			10,484	13
14	**TOTAL Non-Facility Related**						$	$			$ (32,812)	14
15	**TOTALS (line 9+line14)**						$ 7,814,000	$ 6,217,420			$ 184,923	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 27,679 Line # 36

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

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 **Report Period Beginning:** 01/01/2016 **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.**		$ 63,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015	$ 65,185	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,185	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 67,000	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.		$ 72,171	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	69,693	8
	2012	59,284	9
	2013	58,624	10
	2014	60,951	11
	2015	65,185	12

2016 Tax Accrual = 65,185*1.03 = 67,141. Use 67,000.

	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 Caseyville Nursing & Rehabilitation Center, Inc. COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039644

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

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

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

Enter the tax index number and real estate tax assessed for 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.	03-07.0-300-005	Long Term Property Care	$ 65,185.12	$ 65,185.12
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 40,533.35	$ 2,986.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 105,718.47	$ 68,171.12

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 Caseyville Nrsg & Rehab Ctr # 0039644 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	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 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		$ 5,265,179	$	39	$ 146,726	$ 146,726	$ 2,206,462	4
5											5
6											6
7											7
8	Allocated from Management Co.		1995		31,883			911	911	19,727	8
	Improvement Type**										
9	Various			1994	22,304	58	20		(58)	22,304	9
10	Various			1995	52,604	107	20		(107)	52,604	10
11	Various			1996	2,492		20			2,492	11
12	Various			1997	11,349	227	20	567	340	11,065	12
13	Various			1998	14,511		20	726	726	14,280	13
14	Various			1999	83,394		20	4,170	4,170	73,039	14
15	Parking Lot			2000	2,830		20	142	142	2,316	15
16	Sprinkler System			2000	3,385	87	20	169	82	2,819	16
17	Sprinkler System			2000	5,820	149	20	291	142	4,874	17
18	A/C Repairs			2000	1,018		10			1,018	18
19	Ac Repairs			2000	1,102		20	55	55	913	19
20	Draperies			2000	1,052		20	53	53	858	20
21	Carpeting			2000	1,578		20	79	79	1,317	21
22	Air Handler			2000	1,786		20	89	89	1,472	22
23	Air Conditioner			2000	1,963		7			1,324	23
24	Air Handler			2000	1,241		20	62	62	1,023	24
25	Air Conditioner			2000	1,029		20	51	51	853	25
26	Compressor			2000	1,800		20	90	90	1,530	26
27	Booster Heater			2000	1,675		20	84	84	1,427	27
28	Air Conditioner			2000	5,821		20	291	291	4,753	28
29	Air Conditioner			2000	17,320		20	866	866	14,361	29
30	Air Conditioner			2001	3,630		20	182	182	2,848	30
31	Air Conditioner			2001	3,630		20	182	182	2,848	31
32	Air Conditioner			2001	3,111		20	156	156	2,441	32
33	Blinds			2001	1,212		20	61	61	963	33
34	Sprinkler Repair			2001	1,609		20	80	80	1,270	34
35	Sprinkler Heads			2001	2,145		20	107	107	1,678	35
36	Pipes Repair			2001	1,903		20	95		1,434	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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	Dining Room Wall	2002	$ 10,650	$ 191	10	$	$ (191)	$ 10,650	37
38	Water Heater	2002	4,900		12			4,900	38
39	Circuit Breaker	2002	1,390		10			1,390	39
40	Air Conditioners	2002	2,890		7			2,890	40
41	Air Conditioners	2002	4,284		7			4,284	41
42	Water Heater	2002	2,249		12			2,249	42
43	Doors	2003	9,995	256	20	500	244	6,999	43
44	Dry Value System	2003	5,623	144	20	281	137	3,818	44
45	Landscaping	2003	8,800	520	20	440	(80)	5,867	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	22,896	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	1,189	47
48	P.A. Amplifier	2003	713		20	36	36	502	48
49	Security Systems	2004	23,268		20	1,163	1,163	14,540	49
50	16 Transmitters	2004	1,517		20	76	76	949	50
51	Nurses Stations	2004	35,000		20	1,750	1,750	21,875	51
52	Wardrobe units w/ Installation	2004	46,731		20	2,337	2,337	29,210	52
53	Cabinets and Countertops	2005	85,938		20	4,297	4,297	49,415	53
54	Air Conditioners	2005	20,666		7			20,666	54
55	Freezer Door	2005	2,100		20	105	105	1,208	55
56	Wallpaper	2005	16,140		5			16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	3,187	57
58	Painting and Wallcovering	2005	38,520		5			38,520	58
59	Air Condensors	2005	6,270	228	20	314	86	3,609	59
60	Vinyl Flooring	2005	5,009	182	5		(182)	5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	414	15	467	53	5,369	61
62	Metal Doors	2005	1,926	70	20	96	26	1,105	62
63	Kitchen Floor	2006	10,300	375	20	515	140	5,408	63
64	Sprinkler System	2006	9,529	347	20	476	129	5,000	64
65	Door Monitors & Paging System	2006	811		20	41	41	429	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	2,195	66
67	6 A/C Units	2006	2,576		20	129	129	1,354	67
68	6 A/C Units	2006	2,576		20	129	129	1,354	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	2,478	69
70	TOTAL (lines 4 thru 69)		$ 5,968,885	$ 3,881		$ 171,994	$ 168,018	$ 2,752,967	70

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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		$ 5,968,885	$ 3,881		$ 171,994	$ 168,113	$ 2,752,967	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	1,943	2
3	Duct Heater	2006	1,349	49	20	67	18	705	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	4,839	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,019	20	2,895	876	27,503	5
6	4 Hot Water Heaters	2007	13,462	367	20	673	306	6,394	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,435	20	1,973	538	18,742	7
8	Repair Sprinkler System	2007	3,957		20	198	198	1,881	8
9	Oak flooring	2008	15,571	566	20	779	213	6,621	9
10	Fire alarm system	2008	8,858	322	20	443	121	3,765	10
11	Street and parking lot paving	2008	43,360	1,280	20	2,168	888	18,428	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	2,006	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	16,788	13
14	Replace pipe and fitting	2009	4,232	154	20	212	58	1,590	14
15	Air Handling Equipment	2010	22,154	806	20	1,108	302	7,202	15
16	Plumbing Value	2011	4,600	167	20	230	63	1,265	16
17	Hot water system	2011	6,900	251	20	345	94	1,898	17
18	Sprinkler Work	2011	20,035	729	20	1,002	273	5,927	18
19	Direct TV system Installation	2011	7,000		20	350	350	1,925	19
20	Handicap shower stall	2011	2,955	107	20	148	41	813	20
21									21
22	71 Gallon Hot Water Heater: Nurse Station Mechanical Room	2012	3,389	123	20	169	46	763	22
23	100 Gallon Hot Water Heater: Dietary/Maint. Electrical Room	2012	4,917	179	20	246	67	1,106	23
24	Lighting - Electrical Work: All Resident Rooms	2012	9,975	363	20	499	136	2,244	24
25	Fire Alarm: Whole Facility	2012	6,434	234	20	322	88	1,420	25
26									26
27	81 Gallon Hot Water Heater	2013	4,624		7	661	661	2,587	27
28	New Door	2013	3,094		7	442	442	1,363	28
29	100 Gallon Hot Water Heater:	2013	6,236		7	891	891	2,673	29
30									30
31									31
32	Belt Drive Rooftop Ventilator	2014	3,197		10	320	320	773	32
33	Countertop and Back Splash	2014	5,593		10	559	559	1,631	33
34	TOTAL (lines 1 thru 33)		$ 6,325,259	$ 15,110		$ 191,550	$ 176,440	$ 2,897,763	34

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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		$ 6,325,259	$ 15,110		$ 191,550	$ 176,440	$ 2,897,763	1
2	7 Electric Door Holder/Closers	2015	10,102		20	505	505	758	2
3	Walk Path Improvements	2015	15,874		20	794	794	1,191	3
4	Hot Water Heater	2015	3,569		5	714	714	1,071	4
5									5
6	Siding for Cupola	2016	3,677	84	20	92	8	92	6
7	Clinic Service Sink Replacement	2016	3,909	136	20	98	(38)	98	7
8	2 Hot Water Heaters - Mechanical Room	2016	12,531	437	5	1,253	816	1,253	8
9	Hot Water Heater - Nurses Station	2016	7,050	160	5	705	545	705	9
10	Time Clock - 400 Hall in back of building by break room	2016	9,277	5,567	5	928	(4,639)	928	10
11	4 Custom Duct Heaters 200, 300, 400 & 600 halls	2016	3,650	2,190	5	365	(1,825)	365	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	3,568					3,568	19
20	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	594			11	11	592	20
21	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	689					689	21
22	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	589			29	29	552	22
23	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,635			82	82	1,397	23
24	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	3,383			169	169	1,945	24
25	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,915			96	96	910	25
26	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	3,998			200	200	1,499	26
27	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	2,135			107	107	374	27
28	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	2,153			108	108	269	28
29	Allocated from SW Financial Services Co. - Leasehold Improveme	2015	442			29	29	44	29
30									30
31									31
32	To reconcile to financial statements			7,290			(7,290)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,415,999	$ 30,974		$ 197,834	$ 166,860	$ 2,916,062	34

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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	$ 299,898	$	$ 33,015	$ 33,015		$ 183,367	71
72	Current Year Purchases	49,729		9,946	9,946		9,946	72
73	Fully Depreciated Assets	866,047			-		866,047	73
74	Allocated from Management Co.	10,479		187	187		8,985	74
75	TOTALS	$ 1,226,153	$ -	$ 43,148	$ 43,148		$ 1,068,345	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	2011 Chevy Express van	2011	2011	$ 40,007	$	$ 4,001	$ 4,001	5	$ 40,007	76
77							-			77
78							-			78
79	Allocated from Management	2010 Infiniti	2010	5,664			-	5	5,664	79
80	TOTALS			$ 45,671	$ -	$ 4,001	$ 4,001		$ 45,671	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)	$ 8,037,823	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,974	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 244,983	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 214,009	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,030,078	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	CIP	$ 75,000	92
93			93
94			94
95		$ 75,000	95

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

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

16. Rental Amount for movable equipment: $ 732 Description: Nursing Equipment $732
(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 Caseyville Nrsg & Rehab Ctr # 0039644 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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	6,082	$ 437,906	$	6,082	$ 437,906	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,863	89,427		1,863	89,427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		5,835	373,412		5,835	373,412	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				76,275		76,275	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					29,114		29,114	12
13	Other (specify):									13
14	TOTAL			$	13,780	$ 900,745	$ 105,389	13,780	$ 1,006,134	14

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr **#** 0039644 **Report Period Beginning:** 01/01/2016 **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	$ 32,856	$ 231,494	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (74,816))	3,302,367	3,302,367	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,441	32,039	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,045,302	1,647,804	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,402,966	$ 5,213,704	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,297,062	14
15	Leasehold Improvements, at Historical Cost	761,966	1,118,937	15
16	Equipment, at Historical Cost	240,455	1,271,824	16
17	Accumulated Depreciation (book methods)	(576,979)	(4,030,078)	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 Net Cap Costs		139,837	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 425,442	$ 4,147,582	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,828,408	$ 9,361,286	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 168,975	$ 176,755	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,557	37,557	28
29	Short-Term Notes Payable	750,000	750,000	29
30	Accrued Salaries Payable	164,213	164,213	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,939	15,939	31
32	Accrued Real Estate Taxes(Sch.IX-B)		67,000	32
33	Accrued Interest Payable		17,070	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	492,967	581,900	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,629,651	$ 1,810,434	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,467,420	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,467,420	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,629,651	$ 7,277,854	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,198,757	$ 2,083,432	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,828,408	$ 9,361,286	48

***(See instructions.)**

Facility Name: **Caseyville Nrsg & Rehab Ctr**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/2016**

Schedule 17A

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

	Description	Operating	After Consolidation
1201	RE escrow- real estate tax	-	37,930
1137	RE escrow-mip	-	28,467
3015	EMPLOYEE PAYROLL ADVANCE	1,293	1,293
8812	Due from affiliate	-	-
7680	DUE TO PUBLIC AID	3,461	3,461
3030	SHORT TERM LOAN EXCHANGE	838,045	838,045
7052	PRIOR OWNER BALANCE	-	-
2998	RE Escrow - Litigation	-	324,782
8811	DUE/FROM CASEYVILLE PROP. LLC	13,932	13,932
1128	RE Escrow - Insurance	-	16,365
1139	RE replacement reserve	-	194,958
3010	EMPLOYEE LOANS	-	-
2073	DUE FROM STATE - INTEREST	188,571	188,571
	Total - Line 9	**1,045,302**	**1,647,804**

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

	Description	Operating	After Consolidation
7310	ACCRUED EXPENSES	374,039	374,039
2997	RE Due to Lessor - Related Party	-	88,933
2075	DUE TO STATE PER AUDIT	-	-
7055	INSURANCE PREMIUMS PAYABLE	-	-
7610	SHORT TERM LOAN EXCHANGE	-	-
3029	REIMBURSEMENT DUE	6,413	6,413
2070	DUE FROM STATE	112,215	112,215
7145	ACC. RETIREMENT (FROM P/R)	300	300
	Total - Line 36	**492,967**	**581,900**

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 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**	$ 3,024,289	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,024,289	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	174,466	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)		15
16	Other (describe) Rounding	2	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 174,468	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)**	$ 3,198,757	24 *

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 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	$ 6,515,819	1
2	Discounts and Allowances for all Levels	4,828	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,520,647	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	993,762	6
7	Oxygen	27,109	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,020,871	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***	43,083	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43,083	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income**	59	28
28a	**Medicaid Income Adjustment**	16,164	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,223	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,600,824	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,438,897	31
32	Health Care	2,212,548	32
33	General Administration	1,775,419	33
	B. Capital Expense		
34	Ownership	608,344	34
	C. Ancillary Expense		
35	Special Cost Centers	1,071,992	35
36	Provider Participation Fee	319,158	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,426,358	40
41	**Income before Income Taxes (line 30 minus line 40)****	174,466	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 174,466	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,334,195	44
45	Private Pay - Net Inpatient Revenue	997,141	45
46	Medicare - Net Inpatient Revenue	1,095,198	46
47	Other-(specify) **Hospice**	94,113	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,520,647	49

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

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

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

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

^ - This entity is a cash basis taxpayer

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 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	1,916	2,080	$ 81,371	$ 39.12	1
2	Assistant Director of Nursing	1,994	2,078	62,862	30.25	2
3	Registered Nurses	4,481	4,655	130,371	28.01	3
4	Licensed Practical Nurses	24,403	26,297	626,407	23.82	4
5	CNAs & Orderlies	73,999	80,243	949,020	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,237	7,015	90,137	12.85	8
9	Activity Director					9
10	Activity Assistants	5,501	6,002	81,983	13.66	10
11	Social Service Workers	1,841	1,927	37,945	19.69	11
12	Dietician					12
13	Food Service Supervisor	1,971	2,155	49,181	22.82	13
14	Head Cook	7,524	8,317	105,257	12.66	14
15	Cook Helpers/Assistants	12,946	13,939	126,194	9.05	15
16	Dishwashers					16
17	Maintenance Workers	5,624	6,260	142,968	22.84	17
18	Housekeepers	11,992	12,819	139,961	10.92	18
19	Laundry	12,714	13,705	125,502	9.16	19
20	Administrator	2,048	2,080	101,106	48.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	14,324	15,349	418,162	27.24	23
24	Clerical	9,696	10,598	132,435	12.50	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)	199,210	215,518	$ 3,400,862 *	$ 15.78	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,018	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,608	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	Monthly	1,196	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,422		49

C. CONTRACT NURSES

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

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Geralyn Isenberg	Administrator	0	$ 101,106
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,106

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 214,000
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)	$ 334,000

C. Professional Services

Vendor/Payee	Type	Amount
Hepler Broom LLC	Legal	$ 44,885
Lowenbaum Law	Legal	350
Polsinelli	Legal	2,173
RSM US LLP	Accounting	20,911
Unemployment Consultants, Inc.	U/E Consultant	3,600
See SCH 21C		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 71,919

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,146
Unemployment Compensation Insurance	37,939
FICA Taxes	251,827
Employee Health Insurance	60,882
Employee Meals	5,694
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	757
TOTAL (agree to Schedule V, line 22, col.8)	$ 408,245

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 347)	4,158
Patient Background Checks	
Miscellaneous Inspections & Licenses	5,059
Miscellaneous Dues & Permits	952
Illinois Council on Long Term Care	16,200
Allocated from Management Co	88
Allocated from RE Entity	250
Less: Public Relations Expense	( )
Non-allowable advertising	(5,346)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,361

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,099
Allocated from Management Co	195
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,294

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Caseyville Nrsg & Rehab Ctr**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Total on Page 21 for Schedule V, line 19, column 3		71,919
	Total (agree to Schedule V, line 19, column 3)	71,919
Allocated from Real Estate	Professional Services	8,155
Allocated from Management Company	Legal Fees	4
Allocated from Management Company	Professional Services	967
Less: Non-Allowable Legal Fees		(353)
	Total (agree to Schedule V, line 19, column 8)	80,692

Facility Name & ID Number Caseyville Nrsg & Rehab Ctr # 0039644 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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,954** 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. $ **319,158**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,694** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) 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