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: 0047126

Facility Name: St Anthonys Nsg & Rehab Ctr

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

County: Rock Island

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Chris Joos, CPA **Telephone Number:** 614-222-9040
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 01/01/16 to 12/31/16 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) Chris Joos, CPA — Partner
(Firm Name & Address) Plante & Moran, PLLC — 250 S. High Street, Ste 100
(Telephone) 614-222-9040 Fax # 248-233-8811

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	19,032	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,548	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,580	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	5,881	5,080	4,554	15,515	8
9	SNF/PED					9
10	ICF	17,419	2,707	3,208	23,334	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,300	7,787	7,762	38,849	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.65%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/19/05

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 2,637

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	264,589	21,072	13,111	298,772		298,772		298,772			1
2	Food Purchase		366,096		366,096		366,096	(10)	366,086			2
3	Housekeeping	169,103	31,813		200,916		200,916		200,916			3
4	Laundry	54,379	14,007		68,386		68,386		68,386			4
5	Heat and Other Utilities			200,113	200,113		200,113		200,113			5
6	Maintenance	128,524	7,196	130,999	266,719		266,719	7,300	274,019			6
7	Other (specify):* See Supplemental	23,542			23,542		23,542		23,542			7
8	**TOTAL General Services**	640,137	440,184	344,223	1,424,544		1,424,544	7,290	1,431,834			8
	B. Health Care and Programs											
9	Medical Director			28,317	28,317		28,317		28,317			9
10	Nursing and Medical Records	2,247,380	251,596	6,945	2,505,921		2,505,921	24,291	2,530,212			10
10a	Therapy											10a
11	Activities	57,360	7,792	163	65,315		65,315		65,315			11
12	Social Services	33,948	165	804	34,917		34,917		34,917			12
13	CNA Training											13
14	Program Transportation			2,711	2,711		2,711		2,711			14
15	Other (specify):* See Supplemental							4,198	4,198			15
16	**TOTAL Health Care and Programs**	2,338,688	259,553	38,940	2,637,181		2,637,181	28,489	2,665,670			16
	C. General Administration											
17	Administrative	88,092			88,092		88,092	39,334	127,426			17
18	Directors Fees											18
19	Professional Services			744,582	744,582		744,582	(572,941)	171,641			19
20	Dues, Fees, Subscriptions & Promotions			24,929	24,929		24,929	(836)	24,093			20
21	Clerical & General Office Expenses	152,457	20,582	671,812	844,851		844,851	(472,051)	372,800			21
22	Employee Benefits & Payroll Taxes			506,700	506,700		506,700	(6,234)	500,466			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,828	3,828		3,828	8,106	11,934			24
25	Other Admin. Staff Transportation			9,708	9,708		9,708	23,358	33,066			25
26	Insurance-Prop.Liab.Malpractice			82,379	82,379		82,379	73,529	155,908			26
27	Other (specify):* See Supplemental							30,183	30,183			27
28	**TOTAL General Administration**	240,549	20,582	2,043,938	2,305,069		2,305,069	(877,552)	1,427,517			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,219,374	720,319	2,427,101	6,366,794		6,366,794	(841,773)	5,525,021			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security	23,542			23,542
				-
				-
				-
				-
				-
				-
Sub-Total	23,542	-	-	23,542
Line 15 - Other Health Care Services				
Alloc. - SAK Management Services, Inc.				-
Employee Benefits			4,198	4,198
				-
				-
				-
				-
				-
Sub-Total	-	-	4,198	4,198
Line 27 - Other General Administration				
Alloc. - SAK Management Services, Inc.				-
Employee Benefits			30,183	30,183
				-
				-
				-
				-
				-
Sub-Total	-	-	30,183	30,183

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
Loretta Price	Business Matters	Various	Various	8,520			8,520
Diana Kuhlemeier	Business Matters	Various	Various	354			354
Staci Redman	Business Matters	Various	Various	128			128
Keith Hufsey	Business Matters	Various	Various	506			506
Other	Business Matters	Various	Various	200			200
							-
Alloc. - SAK Management Services				23,358			23,358
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
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							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				33,066	-	-	33,066

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr #0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			53,393	53,393		53,393	361,078	414,471			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,657	91,657		91,657	515,715	607,372			32
33	Real Estate Taxes							77,817	77,817			33
34	Rent-Facility & Grounds			1,061,032	1,061,032		1,061,032	(1,034,238)	26,794			34
35	Rent-Equipment & Vehicles			3,937	3,937		3,937	2,316	6,253			35
36	Other (specify):* See Supplemental							68,146	68,146			36
37	TOTAL Ownership			1,210,019	1,210,019		1,210,019	(9,166)	1,200,853			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,598	837,945	907,543		907,543		907,543			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			216,625	216,625		216,625		216,625			42
43	Other (specify):* See Supplemental	43,478	1,413	1,044	45,935		45,935	(45,935)				43
44	TOTAL Special Cost Centers	43,478	71,011	1,055,614	1,170,103		1,170,103	(45,935)	1,124,168			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,262,852	791,330	4,692,734	8,746,916		8,746,916	(896,874)	7,850,042			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
St. Anthony's Property Partners, LLC				-
Mortgage Insurance Premiums			68,146	68,146
				-
				-
				-
				-
				-
Sub-Total	-	-	68,146	68,146
Line 43 - Other Special Cost Centers				
Marketing	43,478	1,413	1,044	45,935
				-
				-
				-
				-
				-
				-
Sub-Total	43,478	1,413	1,044	45,935

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(10)	02		4
5	Telephone, TV & Radio in Resident Rooms	(12,262)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment				19
20	Contributions	(4,125)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(576,360)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(199,560)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (793,747)		$	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)	(103,127)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (103,127)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (896,874)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Anthonys Nsg & Rehab Ctr

ID# 0047126

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (268)	21	1
2	Professional Fees - Legal - Non Allowable	(71,841)	19	2
3	Bank Charges	(27,820)	21	3
4	Theft Loss	(4,131)	21	4
5	Marketing	(45,935)	43	5
6	Capitalized Assets < $2,500	6,933	06	6
7				7
8				8
9				9
10				10
11				11
12				12
13	St. Anthony's Property Partners, LLC			13
14	Professional Fees	(9,550)	19	14
15	Licenses	(500)	20	15
16	Amortization	(24,574)	31	16
17	Interest	(21,874)	32	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**	(199,560)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10)	0	0	0	0	0	0	0	0	0	0	(10)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	6,933	0	367	0	0	0	0	0	0	0	0	7,300	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	6,923	0	367	0	0	0	0	0	0	0	0	7,290	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	24,291	0	0	0	0	0	0	0	0	24,291	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	4,198	0	0	0	0	0	0	0	0	4,198	15
16	**TOTAL Health Care and Programs**	0	0	28,489	0	0	0	0	0	0	0	0	28,489	16
	C. General Administration													
17	Administrative	0	0	39,334	0	0	0	0	0	0	0	0	39,334	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(81,391)	9,550	(501,100)	0	0	0	0	0	0	0	0	(572,941)	19
20	Fees, Subscriptions & Promotions	(4,625)	500	3,289	0	0	0	0	0	0	0	0	(836)	20
21	Clerical & General Office Expenses	(622,271)	0	150,220	0	0	0	0	0	0	0	0	(472,051)	21
22	Employee Benefits & Payroll Taxes	0	0	(6,234)	0	0	0	0	0	0	0	0	(6,234)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,106	0	0	0	0	0	0	0	0	8,106	24
25	Other Admin. Staff Transportation	0	0	23,358	0	0	0	0	0	0	0	0	23,358	25
26	Insurance-Prop.Liab.Malpractice	0	65,334	8,195	0	0	0	0	0	0	0	0	73,529	26
27	Other (specify):*	0	0	30,183	0	0	0	0	0	0	0	0	30,183	27
28	**TOTAL General Administration**	(708,287)	75,384	(244,649)	0	0	0	0	0	0	0	0	(877,552)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(701,364)	75,384	(215,793)	0	0	0	0	0	0	0	0	(841,773)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	352,598	8,480	0	0	0	0	0	0	0	0	361,078	30
31	Amortization of Pre-Op. & Org.	(24,574)	24,574	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,874)	537,217	372	0	0	0	0	0	0	0	0	515,715	32
33	Real Estate Taxes	0	77,817	0	0	0	0	0	0	0	0	0	77,817	33
34	Rent-Facility & Grounds	0	(1,061,032)	26,794	0	0	0	0	0	0	0	0	(1,034,238)	34
35	Rent-Equipment & Vehicles	0	0	2,316	0	0	0	0	0	0	0	0	2,316	35
36	Other (specify):*	0	68,146	0	0	0	0	0	0	0	0	0	68,146	36
37	**TOTAL Ownership**	(46,448)	(680)	37,962	0	0	0	0	0	0	0	0	(9,166)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(45,935)	0	0	0	0	0	0	0	0	0	0	(45,935)	43
44	**TOTAL Special Cost Centers**	(45,935)	0	0	0	0	0	0	0	0	0	0	(45,935)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(793,747)	74,704	(177,831)	0	0	0	0	0	0	0	0	(896,874)	45

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Page 6 - Supp		See Page 6 - Supp		See Page 6 - 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	34	Rent	$ 1,061,032	St. Anthony's Property Partners, LLC	100.00%	$	$ (1,061,032)	1
2	V	32	Interest	74	St. Anthony's Property Partners, LLC	100.00%		(74)	2
3	V	19	Professional Fees		St. Anthony's Property Partners, LLC	100.00%	9,550	9,550	3
4	V	20	Dues, Fees and Subscriptions		St. Anthony's Property Partners, LLC	100.00%	500	500	4
5	V	21	Office and Clerical		St. Anthony's Property Partners, LLC	100.00%			5
6	V	26	Property Insurance		St. Anthony's Property Partners, LLC	100.00%	65,334	65,334	6
7	V	30	Depreciation		St. Anthony's Property Partners, LLC	100.00%	352,598	352,598	7
8	V	31	Amortization		St. Anthony's Property Partners, LLC	100.00%	24,574	24,574	8
9	V	32	Interest		St. Anthony's Property Partners, LLC	100.00%	537,291	537,291	9
10	V	33	Real Estate Taxes		St. Anthony's Property Partners, LLC	100.00%	77,817	77,817	10
11	V	36	Mortgage Insurance		St. Anthony's Property Partners, LLC	100.00%	68,146	68,146	11
12	V								12
13	V								13
14	Total			$ 1,061,106			$ 1,135,810	$ * 74,704	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Suzanne Koenig	90%	Lena Living Center, LLC	Lena, Illinois	St. Anthony's			1
2	Gary Weintraub	10%			Property, LLC	Rock Island, Illinois	Bldg. Partnership	2
3					Lena Property			3
4					Partners, LLC	Lena, Illinois	Bldg. Partnership	4
5					SAK Management	Northfield, Illinois	Mgmt. Company	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								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	6	Maintenance	$	SAK Management Services, LLC	100.00%	$ 367	$ 367	15
16	V	10	Nursing		SAK Management Services, LLC	100.00%	24,291	24,291	16
17	V	10A	Rehab		SAK Management Services, LLC	100.00%	0		17
18	V	15	Emp. Ben. - HC Programs		SAK Management Services, LLC	100.00%	4,198	4,198	18
19	V	17	Administration		SAK Management Services, LLC	100.00%	39,334	39,334	19
20	V	19	Professional Fees	516,367	SAK Management Services, LLC	100.00%	0	(516,367)	20
21	V	19	Professional Fees		SAK Management Services, LLC	100.00%	15,267	15,267	21
22	V	20	Dues and Subscriptions		SAK Management Services, LLC	100.00%	3,289	3,289	22
23	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	150,220	150,220	23
24	V	24	Seminar and Education	393	SAK Management Services, LLC	100.00%	8,499	8,106	24
25	V	25	Other Staff Admin. Trans.		SAK Management Services, LLC	100.00%	169	169	25
26	V	25	Other Staff Admin. Trans.		SAK Management Services, LLC	100.00%	23,189	23,189	26
27	V	26	Insurance		SAK Management Services, LLC	100.00%	8,195	8,195	27
28	V	27	Emp. Ben. - Gen. Admin.		SAK Management Services, LLC	100.00%	30,183	30,183	28
29	V	30	Depreciation		SAK Management Services, LLC	100.00%	8,480	8,480	29
30	V	32	Interest		SAK Management Services, LLC	100.00%	372	372	30
31	V	34	Rent - Building		SAK Management Services, LLC	100.00%	26,794	26,794	31
32	V	35	Rent - Equipment		SAK Management Services, LLC	100.00%	2,316	2,316	32
33	V	22	Employee Benefits	6,234	SAK Management Services, LLC	100.00%		(6,234)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 522,994			$ 345,163	$ * (177,831)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	SAK Consulting Fees	1,665,753	12	$ 1,149	$	532,087	$ 367	1
2	10	Nursing	SAK Consulting Fees	1,665,753	12	76,044	76,044	532,087	24,291	2
3	10A	Rehab	Direct	12,333	12	12,333				3
4	15	Emp. Ben. - HC Programs	SAK Consulting Fees	1,665,753	12	13,143		532,087	4,198	4
5	17	Administration	SAK Consulting Fees	1,665,753	12	123,138	123,138	532,087	39,334	5
6	19	Professional Fees	Direct	1,321	12	1,321				6
7	19	Professional Fees	SAK Consulting Fees	1,665,753	12	47,794		532,087	15,267	7
8	20	Dues and Subscriptions	SAK Consulting Fees	1,665,753	12	10,297		532,087	3,289	8
9	21	Office and Clerical	SAK Consulting Fees	1,665,753	12	470,280	423,857	532,087	150,220	9
10	24	Seminar and Education	SAK Consulting Fees	1,665,753	12	26,608		532,087	8,499	10
11	25	Other Staff Admin. Trans.	Direct	3,557	12	3,557		169	169	11
12	25	Other Staff Admin. Trans.	SAK Consulting Fees	1,665,753	12	72,594		532,087	23,189	12
13	26	Insurance	SAK Consulting Fees	1,665,753	12	25,654		532,087	8,195	13
14	27	Emp. Ben. - Gen. Admin.	SAK Consulting Fees	1,665,753	12	94,490		532,087	30,183	14
15	30	Depreciation	SAK Consulting Fees	1,665,753	12	26,549		532,087	8,480	15
16	32	Interest	SAK Consulting Fees	1,665,753	12	1,165		532,087	372	16
17	34	Rent - Building	SAK Consulting Fees	1,665,753	12	83,880		532,087	26,794	17
18	35	Rent - Equipment	SAK Consulting Fees	1,665,753	12	7,250		532,087	2,316	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,097,246	$ 623,039		$ 345,163	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$ 11,995,400	$ 11,364,153			$ 515,417	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				989,177			63,690	6
7	Monroe Capital		X	Line of Credit				186,447			27,967	7
8	Alloc. - SAK Management										372	8
9	TOTAL Facility Related						$ 11,995,400	$ 12,539,777			$ 607,446	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Interest Income - Bldg Part		X								(74)	13
14	TOTAL Non-Facility Related						$	$			$ (74)	14
15	TOTALS (line 9+line14)						$ 11,995,400	$ 12,539,777			$ 607,372	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 68,146 Line # 36

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.**	$	85,025	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	76,767	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,258)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	86,075	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	77,817	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	87,094	8
	2012	83,397	9
	2013	80,326	10
	2014	79,152	11
	2015	76,767	12

	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

2016 Real Estate Tax Accrual = $76,767 * 1.12 = $86,075

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Anthonys Nsg & Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

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

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

Enter the tax index number and real estate tax assessed for 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.	0736421001	Long Term Care Facility	$ 68,269.04	$ 68,269.04
2.	0736355002	Long Term Care Facility	$ 1,401.48	$ 1,401.48
3.	0736421002	Long Term Care Facility	$ 7,096.56	$ 7,096.56
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,767.08	$ 76,767.08

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		2005		$ 2,050,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	27,609						9
10	Various			2008	18,233						10
11	Various			2009	4,635						11
12	Various			2010	22,384						12
13	Various			2011	17,892						13
14	Water Heater			2013	16,698						14
15	Fire Protection System			2014	26,285						15
16	Boiler Pump - Parts and Repairs			2014	3,963						16
17	Fire Panel			2016	4,936						17
18	Door and Knob Hardware			2016	5,196						18
19											19
20											20
21											21
22											22
23											23
24											24
25	St. Anthony's Property Partners, LLC										25
26											26
27	Complete Facility Rehabilitation and Renovation			2012	6,510,694						27
28	Complete Facility Rehabilitation and Renovation			2013	1,200,533						28
29	Chiller			2016	127,850						29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Depreciation - St. Anthony's Nursing & Rehab Ctr, LLC			53,393		53,393		355,633	67
68	Depreciation - St. Anthony's Property Partners, LLC			352,598		352,598		2,486,683	68
69	Depreciation - SAK Management Services, Inc.			8,480		8,480		38,486	69
70	TOTAL (lines 4 thru 69)		$ 10,036,908	$ 414,471		$ 414,471	$	$ 2,880,802	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 468,432	$	$	$		$	71
72	Current Year Purchases	7,485						72
73	Fully Depreciated Assets							73
74	See Supplemental	798,445						74
75	TOTALS	$ 1,274,362	$	$	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford Windstar	2005	$ 1,506	$	$	$		$	76
77	Facility	Snow Plow Truck	2010	5,500						77
78	Facility	Ford E 350 Bus	2014	15,623						78
79										79
80	TOTALS			$ 22,629	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	11,488,899	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	414,471	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	414,471	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,880,802	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

St Anthonys Nsg & Rehab Ctr
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Page 13 - CY Equipment, Funiture and Vehicle Additions

Related Party	Grouping	Class				Cost
St. Anthony's Property Partners, LLC	Current	Furn. & Equipment				37,365
St. Anthony's Property Partners, LLC	Prior	Furn. & Equipment				710,291
Alloc. - SAK Management Services, Inc.		Furn. & Equipment				50,789
		-	-	-	-	798,445

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	See Suppl				26,794			5
6								6
7	TOTAL				$ 26,794 **			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: $ 6,253 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Anthonys Nsg & Rehab Ctr
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Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
Alloc. - SAK Management Services, Inc.	26,794	26,794
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	26,794	26,794
Equipment Rental		
Culligan of the Quad Cities	368	368
AdvaCare Systems	310	310
Marlin Business Bank	3,259	3,259
		-
Alloc. - SAK Management Services, Inc.	2,316	2,316
		-
		-
		-
		-
		-
		-
		-
		-
Total	6,253	6,253

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 346,221	$		$ 346,221	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			85,615			85,615	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			396,324			396,324	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				68,648		68,648	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					950		950	12
13	Other (specify): See Supplemental	39 - 03				9,785			9,785	13
14	TOTAL			$		$ 837,945	$ 69,598		$ 907,543	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Anthonys Nsg & Rehab Ctr
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Nursing Supplies		950		950
Laboratory			6,703	6,703
Radiology			3,082	3,082
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
				-
Total	-	950	9,785	10,735

STATE OF ILLINOIS

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ 132,407	$ 144,220	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 740,069)	2,258,505	2,258,505	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36,609	36,609	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	91,213	507,318	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,518,734	$ 2,946,652	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,000	13
14	Buildings, at Historical Cost		9,761,227	14
15	Leasehold Improvements, at Historical Cost	10,132	10,132	15
16	Equipment, at Historical Cost	581,259	1,291,550	16
17	Accumulated Depreciation (book methods)	(355,633)	(2,842,316)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		181,016	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 235,758	$ 8,556,609	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,754,492	$ 11,503,261	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,372,712	$ 2,463,194	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,175,626	1,175,626	29
30	Accrued Salaries Payable	265,459	265,459	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,200	5,200	31
32	Accrued Real Estate Taxes(Sch.IX-B)		86,075	32
33	Accrued Interest Payable		50,434	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	2,624,248	2,330,033	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,443,245	$ 6,376,021	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,364,153	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,364,153	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,443,245	$ 17,740,174	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,688,753)	$ (6,236,913)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,754,492	$ 11,503,261	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

St Anthonys Nsg & Rehab Ctr
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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Third Party Payer Settlements	91,213		91,213
Escrow - Replacements		284,868	284,868
Escrow - Real Estate Taxes		8,628	8,628
Escrow - Insurance		122,609	122,609
			-
Sub-Total	91,213	416,105	507,318
Line 23 - Long Term Assets			
Loan Costs (Net of Amortization)		181,016	181,016
			-
			-
			-
			-
Sub-Total	-	181,016	181,016
Line 36 - Other Current Liability			
Due to St. Anthony's Property Partners	489,346	(489,346)	-
Due to Other Affiliated Entities	2,134,902	195,131	2,330,033
			-
			-
			-
Sub-Total	2,624,248	(294,215)	2,330,033
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,891,257)	1
2	Restatements (describe):		2
3	**PY Cost Report to FS Difference**	315,774	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,575,483)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,000,543)	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	(112,727)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,113,270)	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)**	$ (3,688,753)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,437,487	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,437,487	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	307,022	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 307,022	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	376	13
14	Non-Patient Meals	10	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)**	$ 386	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,478	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,478	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,746,373	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,424,544	31
32	Health Care	2,637,181	32
33	General Administration	2,305,069	33
	B. Capital Expense		
34	Ownership	1,210,019	34
	C. Ancillary Expense		
35	Special Cost Centers	953,478	35
36	Provider Participation Fee	216,625	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,746,916	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,000,543)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,000,543)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,609,644	44
45	Private Pay - Net Inpatient Revenue	1,417,898	45
46	Medicare - Net Inpatient Revenue	1,226,864	46
47	Other-(specify) Insurance - Net Patient Revenue	858,019	47
48	Other-(specify) Hospice - Net Patient Revenue	325,062	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,437,487	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final If not, please attach a reconciliation.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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Page 19 Supplemental Schedule

Description	Amount	Total
Vending Commissions	1,210	1,210
Other Income	268	268
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
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		-
		-
		-
Total	1,478	1,478

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,693	1,910	$ 63,811	$ 33.41	1
2	Assistant Director of Nursing	3,318	3,700	107,658	29.10	2
3	Registered Nurses	11,945	13,087	285,515	21.82	3
4	Licensed Practical Nurses	27,940	31,726	704,931	22.22	4
5	CNAs & Orderlies	88,341	96,758	1,085,465	11.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,349	5,810	57,360	9.87	10
11	Social Service Workers	1,928	2,080	33,948	16.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,915	26,934	264,589	9.82	15
16	Dishwashers					16
17	Maintenance Workers	8,165	8,711	128,524	14.75	17
18	Housekeepers	17,803	19,310	169,103	8.76	18
19	Laundry	5,396	6,043	54,379	9.00	19
20	Administrator	1,968	2,080	88,092	42.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,147	8,823	152,457	17.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,590	4,895	67,020	13.69	33
34	TOTAL (lines 1 - 33)	211,498	231,867	$ 3,262,852 *	$ 14.07	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 13,111	01 - 03	35
36	Medical Director		28,317	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,806	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		163	11 - 03	44
45	Social Service Consultant		804	12 - 03	45
46	Other(specify)				46
47	See Supplemental Schedule				47
48					48
49	TOTAL (lines 35 - 48)		$ 48,201		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		1,139	10 - 03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 1,139		53

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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	07	2,698	2,899	23,542	8.12		
Marketing	43	1,892	1,996	43,478	21.78		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		4,590	4,895	67,020	13.69		
Contracted Services							
Total						-	-

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Brill	Administrator	0	$ 88,092
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,092

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
SAK Management Services	Management Fees	$ 372,172
SAK Management Services	Administrative Consultant	139,695
SAK Management Services	Data Processing	4,500
Plante & Moran, PLLC	Accounting	11,895
Change Healthcare	Data Processing	94
Compu-Solutions, Inc.	Data Processing	18,845
COTG	Data Processing	25
Future Wave Tech, Inc.	Data Processing	9,151
Health Data Systems, Inc.	Data Processing	2,800
LTC Solutions	Data Processing	1,063
Mainline Communications	Data Processing	440
See Supplemental Schedule		183,902
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 744,582

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,019
Unemployment Compensation Insurance	51,425
FICA Taxes	237,693
Employee Health Insurance	53,197
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	2,366
Alloc. - SAK Management Services	(6,234)
TOTAL (agree to Schedule V, line 22, col.8)	$ 500,466

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,552
Health Care Worker Background Check	
(Indicate # of checks performed)	4,235
Patient Background Checks	885
Dues - ICLTC	11,700
Dues and Subscriptions	549
Licenses and Permits	883
Alloc. - SAK Management Services	3,289
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,093

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,828
Alloc. - SAK Management Services	8,106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,934

* Attach copy of IMRF notifications

**See instructions.

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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Service Description	Amount	Total
Proliant	Data Processing	8,142	8,142
Silver Streak Logistics	Data Processing	19	19
PointClickCare	Data Processing	15,203	15,203
Personnel Planners	Unemployment Consultant	1,725	1,725
Aronberg, Goldgen, Davis & Garmisa	Legal	150	150
Greenberg Traurig	Legal	14,663	14,663
MPRO	Legal	410	410
Polsinelli Shughart, PC	Legal	124,367	124,367
Stephen N Sher	Legal	2,000	2,000
Stone, Pogrund & Korey, LLC	Legal	4,566	4,566
Accruals	Legal	10,000	10,000
Bank Leumi	Legal	2,657	2,657
			-
			-
			-
			-
			-
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			-
			-
			-
			-
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			-
			-
			-
			-
Total		183,902	183,902

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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Stone Pogrund & Korey LLC	Non - Allowable	01/01/16	1,195	1,195	-
Greenberg Traurig	Non - Allowable	01/04/16	4,091	4,091	-
Greenberg Traurig	Non - Allowable	01/20/16	14,348	14,348	-
Stone Pogrund & Korey LLC	Non - Allowable	01/29/16	1,473	1,473	-
Polsinelli Shughart PC	Non - Allowable	02/01/16	16,341	16,341	-
Polsinelli Shughart PC	Non - Allowable	02/01/16	26,998	26,998	-
MPRO	Corporate / Compliance	02/02/16	410		410
Aronberg Goldgehn Davis & Garmisa	Annual Report	02/09/16	150		150
Stone Pogrund & Korey LLC	Non - Allowable	02/29/16	68	68	-
Polsinelli Shughart PC	Non - Allowable	03/01/16	2,358	2,358	-
Polsinelli Shughart PC	Corporate / Compliance	03/01/16	18,515		18,515
Polsinelli Shughart PC	Corporate / Compliance	03/01/16	2,847		2,847
Polsinelli Shughart PC	Corporate / Compliance	03/07/16	7,646		7,646
Stone Pogrund & Korey LLC	Non - Allowable	03/31/16	397	397	-
Polsinelli Shughart PC	Non - Allowable	04/21/16	2,258	2,258	-
Polsinelli Shughart PC	Corporate / Compliance	05/01/16	8,188		8,188
Stephen N. Sher	Non - Allowable	05/05/16	2,000	2,000	-
Polsinelli Shughart PC	Corporate / Compliance	06/07/16	17,305		17,305
Polsinelli Shughart PC	Corporate / Compliance	06/24/16	10,390		10,390
Stone Pogrund & Korey LLC	Non - Allowable	06/30/16	1,213	1,213	-
Polsinelli Shughart PC	Corporate / Compliance	07/26/16	4,934		4,934
Bank Leumi - fees, line of credit	Non - Allowable	08/05/16	2,657	2,657	-
Greenberg Traurig	Non - Allowable	08/23/16	(3,776)	(3,776)	-
Polsinelli Shughart PC	Corporate / Compliance	09/16/16	6,588		6,588
Stone Pogrund & Korey LLC	Non - Allowable	11/30/16	220	220	-
Accrued Legal Fees	Corporate / Compliance	12/31/16	10,000		10,000
					-
					-
					-
					-
Total			158,813	71,841	86,972

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Page 21 Supplemental Schedule - Seminar

Vendor	Session Title	Seminar Date	Location	Attendee	Amount	Non-Allowable	Allowable
Tri-State Fire Control Inc.		04/28/16	Facility	Various	2,800		2,800
Tri-State Fire Control Inc.		10/19/16	Facility	Various	500		500
SAK Management Services, Inc.		08/22/16			313		313
SAK Management Services, Inc.		10/25/16			80		80
Other		11/28/16			135		135
							-
Alloc - SAK Management Services, Inc.					8,106		8,106
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Total					11,934	-	11,934

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $11,700**

(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 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,745** Line **10 - 02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **216,625**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **10**

(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? **Ln. 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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