FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0039644

Facility Name: Caseyville Nursing & Rehabilitation Center, Inc.

Address: 601 West Lincoln (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 1/01/17 to 12/31/17 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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	975	508	1,606	3,089	8
9	SNF/PED					9
10	ICF	24,898	5,392	5,703	35,993	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,873	5,900	7,309	39,082	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.38%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 1,363

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, I # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	283,920	26,432	6,648	317,000		317,000	-	317,000			1
2	Food Purchase		263,049		263,049		263,049	(25,377)	237,672			2
3	Housekeeping	164,815	39,585	-	204,400		204,400	96	204,496			3
4	Laundry	97,592	14,426	-	112,018	-	112,018	-	112,018			4
5	Heat and Other Utilities			169,568	169,568		169,568	997	170,565			5
6	Maintenance	150,917	79,572	12,648	243,137		243,137	1,633	244,770			6
7	Other (specify):*	-	-	-	-		-	-	-			7
8	TOTAL General Services	697,244	423,064	188,864	1,309,172	-	1,309,172	(22,651)	1,286,521			8
	B. Health Care and Programs											
9	Medical Director	-	-	6,400	6,400		6,400	-	6,400			9
10	Nursing and Medical Records	2,087,631	112,262	13,726	2,213,619		2,213,619	33,277	2,246,896			10
10a	Therapy	-	-	-	-		-	-	-			10a
11	Activities	86,834	12,973	-	99,807		99,807	-	99,807			11
12	Social Services	44,346	-	-	44,346		44,346	-	44,346			12
13	CNA Training	-	-	-	-		-	-	-			13
14	Program Transportation	-	-	-	-		-	-	-			14
15	Other (specify):*	-	-	-	-		-	-	-			15
16	TOTAL Health Care and Programs	2,218,811	125,235	20,126	2,364,172	-	2,364,172	33,277	2,397,449			16
	C. General Administration											
17	Administrative	102,336	-	254,268	356,604		356,604	(236,684)	119,920			17
18	Directors Fees			-	-		-	-	-			18
19	Professional Services			45,245	45,245		45,245	8,796	54,041			19
20	Dues, Fees, Subscriptions & Promotions			28,582	28,582		28,582	(2,055)	26,527			20
21	Clerical & General Office Expenses	458,380	-	73,127	531,507		531,507	45,679	577,186			21
22	Employee Benefits & Payroll Taxes			408,919	408,919		408,919	24,432	433,351			22
23	Inservice Training & Education			-	-		-	-	-			23
24	Travel and Seminar			1,530	1,530		1,530	277	1,807			24
25	Other Admin. Staff Transportation		-	28,247	28,247		28,247	916	29,163			25
26	Insurance-Prop.Liab.Malpractice			222,665	222,665		222,665	18,005	240,670			26
27	Other (specify):* Mgmt Alloc of Benefit	-	-	-	-		-	16,016	16,016			27
28	TOTAL General Administration	560,716	-	1,062,583	1,623,299	-	1,623,299	(124,618)	1,498,681			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,476,771	548,299	1,271,573	5,296,643	-	5,296,643	(113,992)	5,182,651			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 Nursing & Rehabilitation Center, Inc. #0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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			31,362	31,362		31,362	171,014	202,376			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			34,152	34,152		34,152	142,891	177,043			32
33	Real Estate Taxes			-	-		-	75,535	75,535			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)	-			34
35	Rent-Equipment & Vehicles			433	433		433	949	1,382			35
36	Other (specify):* Mortgage Insurance			-	-		-	26,672	26,672			36
37	**TOTAL Ownership**			629,947	629,947	-	629,947	(146,939)	483,008			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	76,508	781,927	858,435		858,435	-	858,435			39
40	Barber and Beauty Shops	-	-	-	-		-	-	-			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			311,492	311,492		311,492	-	311,492			42
43	Other (specify):* Non-Allowable Cos	-	-	51,860	51,860		51,860	(51,860)	-			43
44	**TOTAL Special Cost Centers**	-	76,508	1,145,279	1,221,787	-	1,221,787	(51,860)	1,169,927			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,476,771	624,807	3,046,799	7,148,377	-	7,148,377	(312,791)	6,835,586			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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	(23,026)	30		9
10	Interest and Other Investment Income	(59,665)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(495)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,663)	43		24
25	Fund Raising, Advertising and Promotional	(4,974)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(32,847)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,070)		$	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)	(172,721)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (172,721)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (312,791)		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

STATE OF ILLINOIS

Caseyville Nursing & Rehabilitation Center, Inc.

ID# 0039644

Report Period Beginning: 1/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (11,354)	43	1
2	X Ray Expense Med A	(3,685)	43	2
3	Managed Care Cost	(11,972)	43	3
4	Collections	(317)	43	4
5	Offset Miscellaneous Income	(173)	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
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**	(32,847)		49

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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%	$ 7,780	$ 7,780	1
2	V	20	Dues, Fees, Subs. & Promotions		Caseyville Property LLC	100%			2
3	V	21	Miscellaneous Income		Caseyville Property LLC	100%			3
4	V	26	Insurance-Prop.Liab.Malpractice		Caseyville Property LLC	100%	16,831	16,831	4
5	V	30	Depreciation		Caseyville Property LLC	100%	191,035	191,035	5
6	V	32	Interest	111	Caseyville Property LLC	100%	197,747	197,636	6
7	V	32	Amortization		Caseyville Property LLC	100%			7
8	V	32	Debt Issuance Cost		Caseyville Property LLC	100%	4,920	4,920	8
9	V	33	Real Estate Taxes		Caseyville Property LLC	100%	72,448	72,448	9
10	V	34	Rent	564,000	Caseyville Property LLC	100%		(564,000)	10
11	V	36	Mortgage Insurance		Caseyville Property LLC	100%	26,672	26,672	11
12	V								12
13	V								13
14	Total			$ 564,111			$ 517,433	$ * (46,678)	14

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Financial Services Company	100.00%	$ 27	$ 27	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	96	96	16
17	V	5	Utilities		SW Financial Services Company	100.00%	997	997	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	1,633	1,633	18
19	V	17	Administrative	254,268	SW Financial Services Company	100.00%	17,584	(236,684)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,016	1,016	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	919	919	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	81,501	81,501	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	277	277	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	916	916	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	1,174	1,174	25
26	V	27	Other		SW Financial Services Company	100.00%	16,016	16,016	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	3,005	3,005	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	3,087	3,087	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	949	949	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			$ 254,268			$ 129,197	$ * (125,071)	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	$ 10,685	S & E Medical Supply Co.	95.00%	$ 9,713	$ (972)	15
16	V								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			$ 10,685			$ 9,713	$ * (972)	39

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	Maple Crossing at Amboy	Amboy	Hospice			8
9	Michael A Klein as Trustee	6.67			Forest View Senior	Independence, MO	Independent	9
10	Kenneth Klein	4.99	Tower Hill Rehabilitation LLC	South Elgin	Residences		Living	10
11	Susat Stern	4.67			White Oak Living	Independence, MO	Residential	11
12	Jonathan B Stern 2001 Trust	1.56	Beauvais Manor Healthcare and Rehab	St. Louis, MO	Center		Care	12
13	Todd A. Stern 2001 Trust	1.56	Hillside Manor Healthcare and Rehab	St. Louis, MO				13
14	Evan M. Stern	1.56	Rancho Manor Healthcare and Rehab	Florissant, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15	Moshe Herman	0.67	Rosewood Health & Rehab	Independence, MO	Program LLC			15
16	Ora Aaron	4.67	Seasons Care Center	Kansas City, MO				16
17			Carriage Square Living & Rehab	St. Joseph, MO	Cahokia Building LLC	Cahokia	Real Estae	17
18			Linn Living & Rehabilitation Center	Linn, MO	Caseyville Property LL	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20					Property LLC			20
21								21
22					FOM Property LLC	Franklin Grove	Real Estate	22
23								23
24					Oregon Property LLC	Oregon	Real Estate	24
25					Prairie Crossing	Shabbona	Real Estate	25
26					Property LLC			26
27								27
28					Tower Hill Property L	South Elgin	Real Estate	28
29		0						29
30		0						30

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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 Nursing & Rehabilitation Center, # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	4	8.89	Salary	$ 3,822	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	$ 3,822		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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	736,091	14	$ 368	$	54,750	$ 27	1
2	3	Housekeeping	Bed Days Available	736,091	14	1,294		54,750	96	2
3	5	Utilities	Bed Days Available	736,091	14	13,401		54,750	997	3
4	6	Maintenance	Bed Days Available	736,091	14	21,957		54,750	1,633	4
5	19	Professional Services-Legal	Bed Days Available	736,091	14	314		54,750	23	5
6	19	Professional Services-Other	Bed Days Available	736,091	14	13,344		54,750	993	6
7	20	Dues, Fees, Subs. & Promotions	Bed Days Available	736,091	14	12,352		54,750	919	7
8	21	Clerical & General Office Expense	Bed Days Available	736,091	14	904,631		54,750	67,286	8
9	21	Clerical & General Office Expense	Bed Days Available	736,091	14	191,115		54,750	14,215	9
10	24	Travel & Seminar	Bed Days Available	736,091	14	3,725		54,750	277	10
11	25	Other Admin. Staff Transportion	Bed Days Available	736,091	14	12,311		54,750	916	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	736,091	14	15,785		54,750	1,174	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	736,091	14	215,324		54,750	16,016	13
14	33	Real Estate Taxes	Bed Days Available	736,091	14	41,499		54,750	3,087	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	736,091	14	12,753		54,750	949	15
16										16
17	17	Administrative - Salary	Average Hours Worked	45	14	43,000	43,000	4	3,822	17
18	17	Administrative - Salary	Average Hours Worked	45	14	154,818	154,818	4	13,762	18
19										19
20	30	Depreciation	Direct Cost	40,403					3,005	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,657,991	$ 197,818		$ 129,197	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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 Commerical 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			$	$		$ 9,713	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					$	$		$ 9,713	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center,] # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage	$38,896.00	11/27/01	$ 6,814,000	$ 5,279,061	12/1/36	0.0635	$ 197,747	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Member Loan	X		Working Capital	Varies	5/15/2016	1,000,000	467,405	5/15/2017	0.0500	34,152	6
7												7
8												8
9	TOTAL Facility Related				$38,896.00		$ 7,814,000	$ 5,746,466			$ 231,899	9
	B. Non-Facility Related*											
10												10
11								Debt Issuance Cost			4,920	11
12								Interest Income			(59,776)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (54,856)	14
15	TOTALS (line 9+line14)						$ 7,814,000	$ 5,746,466			$ 177,043	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,672 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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 67,000	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.)	2016	$ 68,448	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,448	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 71,000	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.	$ 3,087	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.		$ 75,535	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	59,284	8
	2013	58,624	9
	2014	60,951	10
	2015	65,185	11
	2016	68,448	12

2017 Tax Accrual = 68,448*1.03 = 70,501. Use 70,500.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(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	$ 68,447.96	$ 68,447.96
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 40,533.35	$ 3,087.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,981.31	$ 71,534.96

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	$ 124,105	$ 124,105	$ 2,330,567	4
5						-		-			5
6						-		-			6
7						-		-			7
8	Allocated from Management Co.		1995		32,065	-		916	916	20,755	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	284	57	11,349	12
13	Various			1998	14,511		20	231	231	14,511	13
14	Various			1999	83,394		20	4,170	4,170	77,209	14
15	Parking Lot			2000	2,830		20	142	142	2,458	15
16	Sprinkler System			2000	3,385	87	20	169	82	2,988	16
17	Sprinkler System			2000	5,820	149	20	291	142	5,165	17
18	A/C Repairs			2000	1,018		10			1,018	18
19	Ac Repairs			2000	1,102		20	55	55	968	19
20	Draperies			2000	1,052		20	53	53	911	20
21	Carpeting			2000	1,578		20	79	79	1,396	21
22	Air Handler			2000	1,786		20	89	89	1,561	22
23	Air Conditioner			2000	1,963		7			1,324	23
24	Air Handler			2000	1,241		20	62	62	1,085	24
25	Air Conditioner			2000	1,029		20	51	51	904	25
26	Compressor			2000	1,800		20	90	90	1,620	26
27	Booster Heater			2000	1,675		20	84	84	1,511	27
28	Air Conditioner			2000	5,821		20	291	291	5,044	28
29	Air Conditioner			2000	17,320		20	866	866	15,227	29
30	Air Conditioner			2001	3,630		20	182	182	3,030	30
31	Air Conditioner			2001	3,630		20	182	182	3,030	31
32	Air Conditioner			2001	3,111		20	156	156	2,597	32
33	Blinds			2001	1,212		20	61	61	1,024	33
34	Sprinkler Repair			2001	1,609		20	80	80	1,350	34
35	Sprinkler Heads			2001	2,145		20	107	107	1,785	35
36	Pipes Repair			2001	1,903		20	95	95	1,529	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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	7,499	43
44	Dry Value System	2003	5,623	144	20	281	137	4,099	44
45	Landscaping	2003	8,800	519	20	440	(79)	6,307	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	24,646	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	1,274	47
48	P.A. Amplifier	2003	713		20	36	36	538	48
49	Security Systems	2004	23,268		20	1,163	1,163	15,703	49
50	16 Transmitters	2004	1,517		20	76	76	1,025	50
51	Nurses Stations	2004	35,000		20	1,750	1,750	23,625	51
52	Wardrobe units w/ Installation	2004	46,731		20	2,337	2,337	31,547	52
53	Cabinets and Countertops	2005	85,938		20	4,297	4,297	53,712	53
54	Air Conditioners	2005	20,666		7			20,666	54
55	Freezer Door	2005	2,100		20	105	105	1,313	55
56	Wallpaper	2005	16,140		5			16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	3,464	57
58	Painting and Wallcovering	2005	38,520		5			38,520	58
59	Air Condensors	2005	6,270	228	20	314	86	3,923	59
60	Vinyl Flooring	2005	5,009	182	5		(182)	5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	413	15	467	54	5,836	61
62	Metal Doors	2005	1,926	70	20	96	26	1,201	62
63	Kitchen Floor	2006	10,300	375	20	515	140	5,923	63
64	Sprinkler System	2006	9,529	346	20	476	130	5,476	64
65	Door Monitors & Paging System	2006	811		20	41	41	470	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	2,404	66
67	6 A/C Units	2006	2,576		20	129	129	1,483	67
68	6 A/C Units	2006	2,576		20	129	129	1,483	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	2,714	69
70	TOTAL (lines 4 thru 69)		$ 5,969,067	$ 3,878		$ 148,597	$ 144,719	$ 2,901,679	70

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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		$ 5,969,067	$ 3,878		$ 148,597	$ 144,719	$ 2,901,679	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3702	135	20	185	50	2,128	2
3	Duct Heater	2006	1349	49	20	67	18	772	3
4	Shower Room Remodel (E Hall)	2006	9210	335	20	461	126	5,300	4
5	Demolish and Rebuild Shower Room	2007	57900	2,018	20	2,895	877	30,398	5
6	4 Hot Water Heaters	2007	13462	367	20	673	306	7,067	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39450	1,434	20	1,973	539	20,715	7
8	Repair Sprinkler System	2007	3957		20	198	198	2,079	8
9	Oak flooring	2008	15571	566	20	779	213	7,400	9
10	Fire alarm system	2008	8858	322	20	443	121	4,208	10
11	Street and parking lot paving	2008	43360	1,280	20	2,168	888	20,596	11
12	Replace 3 inch main	2008	4716	171	20	236	65	2,242	12
13	Replace hot water pipes	2008	39504	1,437	20	1,975	538	18,763	13
14	Replace pipe and fitting	2009	4232	154	20	212	58	1,802	14
15	Air Handling Equipment	2010	22154	806	20	1,108	302	8,310	15
16	Plumbing Value	2011	4600	167	20	230	63	1,495	16
17	Hot water system	2011	6900	251	20	345	94	2,243	17
18	Sprinkler Work	2011	20035	729	20	1,002	273	6,929	18
19	Direct TV system Installation	2011	7000		20	350	350	2,275	19
20	Handicap shower stall	2011	2955	107	20	148	41	961	20
21									21
22	71 Gallon Hot Water Heater: Nurse Station Mechanical Room	2012	3389	123	20	169	46	932	22
23	100 Gallon Hot Water Heater: Dietary/Maint. Electrical Room	2012	4917	179	20	246	67	1,352	23
24	Lighting - Electrical Work: All Resident Rooms	2012	9975	363	20	499	136	2,743	24
25	Fire Alarm: Whole Facility	2012	6434	234	20	322	88	1,742	25
26									26
27	81 Gallon Hot Water Heater	2013	4624		7	661	661	3,248	27
28	New Door	2013	3094		7	442	442	1,805	28
29	100 Gallon Hot Water Heater:	2013	6236		7	891	891	3,564	29
30									30
31									31
32	Belt Drive Rooftop Ventilator	2014	3197		10	320	320	1,092	32
33	Countertop and Back Splash	2014	5593		10	559	559	2,191	33
34	TOTAL (lines 1 thru 33)		$ 6,325,441	$ 15,105		$ 168,151	$ 153,046	$ 3,066,031	34

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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		$ 6,325,441	$ 15,105		$ 168,151	$ 153,046	$ 3,066,031	1
2	7 Electric Door Holder/Closers	2015	10,102		20	505	505	1,263	2
3	Walk Path Improvements	2015	15,874		20	794	794	1,984	3
4	Hot Water Heater	2015	3,569	130	5	714	584	1,785	4
5									5
6	Siding for Cupola	2016	3,677	134	20	184	50	276	6
7	Clinic Service Sink Replacement	2016	3,909	142	20	195	53	293	7
8	2 Hot Water Heaters - Mechanical Room	2016	12,531	456	5	2,506	2,050	3,759	8
9	Hot Water Heater - Nurses Station	2016	7,050	256	5	1,410	1,154	2,115	9
10	Time Clock - 400 Hall in back of building by break room	2016	9,277	1,484	5	1,855	371	2,783	10
11	4 Custom Duct Heaters 200, 300, 400 & 600 halls	2016	3,650	584	5	730	146	1,095	11
12									12
13	Walk-In Cooler - Kitchen	2017	18,495	421	20	308	(113)	308	13
14	Install Fire Alarm	2017	3,430	57	20	86	29	86	14
15	98 gallon Water heater	2017	13,801	356	5	2,070	1,714	2,070	15
16	Install Sprinkler System - Entire Building	2017	250,800		20	6,270	6,270	6,270	16
17	Plan Submission Fee for Sprinklers - Entire Building	2017	3,010	95	5	552	457	552	17
18									18
19	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	3,589					3,589	19
20	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	597			2	2	597	20
21	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	693					693	21
22	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	592			30	30	585	22
23	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,645			82	82	1,487	23
24	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	3,402			170	170	2,127	24
25	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,926			96	96	1,011	25
26	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	4,021			201	201	1,709	26
27	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	2,147			107	107	483	27
28	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	2,165			108	108	379	28
29	Allocated from SW Financial Services Co. - Leasehold Improveme	2015	444			30	30	74	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,705,837	$ 19,220		$ 187,157	$ 167,937	$ 3,103,404	34

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	$ 129,218	$ 7,160	$ 12,909	$ 5,749		$ 85,686	71
72	Current Year Purchases	8,303	4,982	1,047	(3,935)	5	1,047	72
73	Fully Depreciated Assets	875,467					875,467	73
74	Allocated from Management Co.	13,231		477	477		9,513	74
75	TOTALS	$ 1,026,219	$ 12,142	$ 14,434	$ 2,292		$ 971,714	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	$ -	$ -	$	5	$ 40,007	76
77					-	-				77
78					-	-				78
79	Allocated from Management	2017 Land Rover Evoque	2017	7,854	-	785	785	5	785	79
80	TOTALS			$ 47,861	$	$ 785	$ 785		$ 40,792	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)	$ 8,129,917	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,362	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 202,376	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 171,014	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,115,910	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		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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				N/A			4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 433 Description: Respiratory Equipment $433
(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.		$	$ 949	17
18					18
19					19
20					20
21	TOTAL		$	$ 949	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 Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	$	6,082	$ 363,769	$	6,082	$ 363,769	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,863	101,201		1,863	101,201	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		5,835	316,957		5,835	316,957	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				56,007		56,007	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					20,501		20,501	12
13	Other (specify):									13
14	TOTAL			$	13,780	$ 781,927	$ 76,508	13,780	$ 858,435	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 Nursing & Rehabilitation Center, Inc. **#** 0039644 **Report Period Beginning:** 1/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 **(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	$ 243,594	$ 347,809	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,057)	2,023,589	2,023,589	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,702	34,300	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,345,864	1,774,670	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,637,749	$ 4,180,368	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		5,297,244	14
15	Leasehold Improvements, at Historical Cost	783,891	1,408,593	15
16	Equipment, at Historical Cost	265,569	1,074,080	16
17	Accumulated Depreciation (book methods)	(608,341)	(4,115,910)	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 **Capitalized Costs**		59,917	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 441,119	$ 4,073,924	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,078,868	$ 8,254,292	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,880	$ 57,880	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,773	37,773	28
29	Short-Term Notes Payable	467,405	467,405	29
30	Accrued Salaries Payable	176,301	176,301	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,427	15,427	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,000	32
33	Accrued Interest Payable		16,233	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	482,639	549,596	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,237,425	$ 1,391,615	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,279,061	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)**	$	$ 5,279,061	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,237,425	$ 6,670,676	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,841,443	$ 1,583,616	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,078,868	$ 8,254,292	48

***(See instructions.)**

Facility Name: **Caseyville Nursing & Rehabilitation Center, Inc.**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/17**

Schedule 17A

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

	Description	Operating	After Consolidation
1128	RE Escrow - Insurance	-	26,419
1137	RE escrow-mip	-	31,795
1139	RE replacement reserve	-	90,028
1201	RE escrow- real estate tax	-	35,782
2073	DUE FROM STATE - INTEREST	232,697	232,697
2998	RE Escrow - Litigation	-	244,782
3015	EMPLOYEE PAYROLL ADVANCE	681	681
3030	SHORT TERM LOAN EXCHANGE	1,173,310	1,173,310
8811	DUE/FROM CASEYVILLE PROP. LLC	(60,824)	(60,824)
	Total - Line 9	**1,345,864**	**1,774,670**

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

	Description	Operating	After Consolidation
2070	DUE FROM STATE	112,215	112,215
3029	REIMBURSEMENT DUE	803	803
7310	ACCRUED EXPENSES	369,621	369,621
2997	RE Due to Lessor - Related Party	-	59,177
7055	INSURANCE PREMIUMS PAYABLE	-	7,780
	Total - Line 36	**482,639**	**549,596**

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,198,757	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,198,757	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(357,314)	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)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (357,314)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,841,443	24 *

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	$ 5,788,892	1
2	Discounts and Allowances for all Levels	20,536	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,809,428	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	896,575	6
7	Oxygen	20,522	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 917,097	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***	59,665	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,665	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income**	173	28
28a	**Medicaid Income Adjustment**	4,700	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,873	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,791,063	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,309,172	31
32	Health Care	2,364,172	32
33	General Administration	1,623,299	33
	B. Capital Expense		
34	Ownership	629,947	34
	C. Ancillary Expense		
35	Special Cost Centers	910,295	35
36	Provider Participation Fee	311,492	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,148,377	40
41	**Income before Income Taxes (line 30 minus line 40)****	(357,314)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (357,314)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,972,123	44
45	Private Pay - Net Inpatient Revenue	1,104,075	45
46	Medicare - Net Inpatient Revenue	637,502	46
47	Other-(specify) **Hospice**	95,728	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,809,428	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.**

^ Entitiy is a tax basis taxpayer.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	1,996	2,080	$ 80,877	$ 38.88	1
2	Assistant Director of Nursing	1,147	1,305	36,796	28.20	2
3	Registered Nurses	5,400	5,647	199,368	35.31	3
4	Licensed Practical Nurses	24,869	26,697	707,390	26.50	4
5	CNAs & Orderlies	77,950	84,242	1,063,200	12.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,500	6,191	86,834	14.03	10
11	Social Service Workers	2,053	2,181	44,346	20.33	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,216	52,255	23.58	13
14	Head Cook	7,082	8,100	107,277	13.24	14
15	Cook Helpers/Assistants	12,572	13,435	124,388	9.26	15
16	Dishwashers					16
17	Maintenance Workers	5,825	6,340	150,917	23.80	17
18	Housekeepers	14,470	15,127	164,815	10.90	18
19	Laundry	9,846	10,656	97,592	9.16	19
20	Administrator	1,848	2,080	102,336	49.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	12,600	14,282	354,172	24.80	23
24	Clerical	6,911	7,506	104,208	13.88	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)					33
34	TOTAL (lines 1 - 33)	192,077	208,085	$ 3,476,771 *	$ 16.71	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	$ 6,648	L1, C3	35
36	Medical Director	Monthly	6,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,484	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,532		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	127	5,242	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	127	$ 5,242		53

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Geralyn Isenberg	Administrator	0	$ 102,336
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,336

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 234,268
Management Fees	20,000
(Eliminated on Sch V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 254,268
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hepler Broom LLC	Legal	$ 24,545
MB Loan	Legal	595
Polsinelli	Legal	913
RSM US	Accounting	19,192
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 45,245

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,884
Unemployment Compensation Insurance	27,459
FICA Taxes	258,509
Employee Health Insurance	78,984
Employee Meals	24,432
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	1,012
Employee Life Insurance	5,071
TOTAL (agree to Schedule V, line 22, col.8)	$ 433,351

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 132)	1,589
Patient Background Checks 293	2,930
Miscellaneous Inspections & Licenses	2,326
Miscellaneous Dues & Permits	3,929
Illinois Council on Long Term Care	16,200
Allocated from Management Co	919
Allocated from RE Entity	
Less: Public Relations Expense	( )
Non-allowable advertising	(5,346)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,527

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,530
Allocated from Management Co.	277
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,807

**See instructions.

Facility Name: **Caseyville Nursing & Rehabilitation Center, Inc.**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/17**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Hepler Broom LLC	Legal	24,545
MB Loan	Legal	595
Polsinelli	Legal	913
RSM US	Accounting	19,192

Total (agree to Schedule V, line 19, column 3)		45,245
Allocated from Management Company	Legal Fees	23
Allocated from Management Company	Professional Services	993
Allocated from Real Estate Entity	Professional Services	7,780
Total (agree to Schedule V, line 19, column 8)		54,041

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,508** 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. $ **311,492**
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. $ **24,432** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **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