FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0039644

Facility Name: Caseyville 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 1/1/18 to 12/31/18 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: 1/1/18 Ending: 12/31/18

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	511	613	1,479	2,603	8
9	SNF/PED					9
10	ICF	25,300	4,573	6,581	36,454	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,811	5,186	8,060	39,057	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.34%

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 1,298

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

STATE OF ILLINOIS

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, I # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	300,933	28,888	6,792	336,613		336,613	-	336,613			1
2	Food Purchase		266,198		266,198		266,198	(24,136)	242,062			2
3	Housekeeping	160,163	43,443	-	203,606		203,606	52	203,658			3
4	Laundry	96,107	15,350	-	111,457		111,457	-	111,457			4
5	Heat and Other Utilities			172,021	172,021		172,021	1,258	173,279			5
6	Maintenance	150,647	58,794	12,436	221,877		221,877	2,157	224,034			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	707,850	412,673	191,249	1,311,772		1,311,772	(20,669)	1,291,103			8
	B. Health Care and Programs											
9	Medical Director	-	-	4,800	4,800		4,800	-	4,800			9
10	Nursing and Medical Records	2,097,562	82,808	3,141	2,183,511		2,183,511	26,002	2,209,513			10
10a	Therapy	2,118	-	-	2,118		2,118	-	2,118			10a
11	Activities	76,513	10,948	-	87,461		87,461	-	87,461			11
12	Social Services	40,430	-	-	40,430		40,430	-	40,430			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	2,216,623	93,756	7,941	2,318,320		2,318,320	26,002	2,344,322			16
	C. General Administration											
17	Administrative	102,337	-	258,060	360,397		360,397	(237,263)	123,134			17
18	Directors Fees			-				-				18
19	Professional Services			62,410	62,410		62,410	8,211	70,621			19
20	Dues, Fees, Subscriptions & Promotions			27,547	27,547		27,547	(6,489)	21,058			20
21	Clerical & General Office Expenses	451,210	-	62,350	513,560		513,560	49,039	562,599			21
22	Employee Benefits & Payroll Taxes			434,203	434,203		434,203	23,738	457,941			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			2,000	2,000		2,000	34	2,034			24
25	Other Admin. Staff Transportation		-	24,169	24,169		24,169	735	24,904			25
26	Insurance-Prop.Liab.Malpractice			214,079	214,079		214,079	19,392	233,471			26
27	Other (specify):* Mgmt Alloc of Benefit	-	-	-				19,546	19,546			27
28	**TOTAL General Administration**	553,547		1,084,818	1,638,365		1,638,365	(123,057)	1,515,308			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,478,020	506,429	1,284,008	5,268,457		5,268,457	(117,724)	5,150,733			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: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			32,183	32,183		32,183	192,008	224,191			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			31,902	31,902		31,902	166,392	198,294			32
33	Real Estate Taxes			-				72,325	72,325			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)				34
35	Rent-Equipment & Vehicles			57	57		57	987	1,044			35
36	Other (specify):* Mortgage Insurance			-				23,721	23,721			36
37	**TOTAL Ownership**			628,142	628,142		628,142	(108,567)	519,575			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	75,706	757,313	833,019		833,019	-	833,019			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			315,116	315,116		315,116	-	315,116			42
43	Other (specify):* Non-Allowable Cos	-	-	39,013	39,013		39,013	(39,013)				43
44	**TOTAL Special Cost Centers**		75,706	1,111,442	1,187,148		1,187,148	(39,013)	1,148,135			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,478,020	582,135	3,023,592	7,083,747		7,083,747	(265,304)	6,818,443			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: 1/1/18 Ending: 12/31/18

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	3,051	30		9
10	Interest and Other Investment Income	(27,721)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(480)	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	(600)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(912)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,083)	43		24
25	Fund Raising, Advertising and Promotional	(1,500)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,846)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(35,952)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,043)		$	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)	(187,261)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (187,261)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (265,304)		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: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (5,918)	43	1
2	X Ray Expense Med A	(4,189)	43	2
3	Managed Care Cost	(12,397)	43	3
4	Offset Miscellaneous Income	(3,523)	21	4
5	Lobbying Expense	(9,925)	20	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
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**	(35,952)		49

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Caseyville Property LLC	100%	$ 8,000	$ 8,000	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%	18,274	18,274	4
5	V	30	Depreciation		Caseyville Property LLC	100%	185,079	185,079	5
6	V	32	Interest	83	Caseyville Property LLC	100%	194,196	194,113	6
7	V	32	Amortization		Caseyville Property LLC	100%			7
8	V	32	Debt Issuance Cost		Caseyville Property LLC	100%			8
9	V	33	Real Estate Taxes		Caseyville Property LLC	100%	69,113	69,113	9
10	V	34	Rent	564,000	Caseyville Property LLC	100%		(564,000)	10
11	V	36	Mortgage Insurance		Caseyville Property LLC	100%	23,721	23,721	11
12	V								12
13	V								13
14	Total			$ 564,083			$ 498,383	$ * (65,700)	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: 1/1/18 Ending: 12/31/18

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%	$ 258	$ 258	15
16	V	3	Housekeeping		SW Financial Services Company	100%	52	52	16
17	V	5	Utilities		SW Financial Services Company	100%	1,258	1,258	17
18	V	6	Maintenance		SW Financial Services Company	100%	2,157	2,157	18
19	V	17	Administrative	258,060	SW Financial Services Company	100%	20,797	(237,263)	19
20	V	19	Professional Services		SW Financial Services Company	100%	1,123	1,123	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Financial Services Company	100%	391	391	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100%	81,609	81,609	22
23	V	24	Travel & Seminar		SW Financial Services Company	100%	34	34	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100%	735	735	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100%	1,118	1,118	25
26	V	27	Other		SW Financial Services Company	100%	19,546	19,546	26
27	V	30	Depreciation		SW Financial Services Company	100%	3,878	3,878	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100%	3,212	3,212	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100%	987	987	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			$ 258,060			$ 137,155	$ * (120,905)	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: 1/1/18 Ending: 12/31/18

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	$ 7,217	S & E Medical Supply Co.	95.00%	$ 6,560	$ (656)	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			$ 7,217			$ 6,560	$ * (656)	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: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Abraham J Stern	4.67	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing Supp	Shabbona	Supportive Living	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Sheldon Wolfe	23.67			SW Financial	Skokie	Bookkeeping/	3
4	Ronnie Klein as Trustee	4.99			Services Co.		Management Comp	4
5	Maurice Aaron	4.67	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Michael Klein Revocable Trust	1.99	Oregon Living & Rehabilitation, LLC	Oregon				6
7	Wanda Bowling	0.67	Prairie Crossing Living & Rehab Center	Shabbona	Groves Community	Independence, MO	Hospice	7
8	Miriam Y Klein as Trustee	6.67	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					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								29
30								30

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

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								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: 1/1/18 Ending: 12/31/18

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	5	11.11	Salary	$ 1,444	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	$ 1,444		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: 1/1/18 Ending: 12/31/18

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	710,112	13	$ 3,344	$	54,750	$ 258	1
2	3	Housekeeping	Bed Days Available	710,112	13	674		54,750	52	2
3	5	Utilities	Bed Days Available	710,112	13	16,315		54,750	1,258	3
4	6	Maintenance	Bed Days Available	710,112	13	27,981		54,750	2,157	4
5	19	Professional Services-Legal	Bed Days Available	710,112	13	455		54,750	35	5
6	19	Professional Services-Other	Bed Days Available	710,112	13	14,116		54,750	1,088	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	710,112	13	5,074		54,750	391	7
8	21	Clerical & General Office Expens	Bed Days Available	710,112	13	891,312	891,312	54,750	68,721	8
9	21	Clerical & General Office Expens	Bed Days Available	710,112	13	167,154		54,750	12,888	9
10	24	Travel & Seminar	Bed Days Available	710,112	13	440		54,750	34	10
11	25	Other Admin. Staff Transportion	Bed Days Available	710,112	13	9,537		54,750	735	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	710,112	13	14,506		54,750	1,118	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	710,112	13	253,509		54,750	19,546	13
14	33	Real Estate Taxes	Bed Days Available	710,112	13	41,656		54,750	3,212	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	710,112	13	12,804		54,750	987	15
16										16
17	17	Administrative - Salary	Average Hours Worked	45	13	13,000	13,000	5	1,444	17
18	17	Administrative - Salary	Average Hours Worked	45	13	174,173	174,173	5	19,353	18
19										19
20	30	Depreciation	Direct Cost	50,298					3,878	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,646,050	$ 1,078,485		$ 137,155	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			$	$		$ 6,560	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					$	$		$ 6,560	25

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, l # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage	38,896	11/27/2001	$ 6,814,000	$ 5,086,916	12/1/2036	0.0635	$ 194,196	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Member Loan	X		Working Capital	Varies	5/15/2016	1,000,000	797,844	5/15/2017	0.05	31,902	6
7												7
8												8
9	TOTAL Facility Related				$38,896.00		$ 7,814,000	$ 5,884,760			$ 226,098	9
	B. Non-Facility Related*											
10												10
11								Interest Income			(27,804)	11
12								Allocated from Mgmt Co.				12
13												13
14	TOTAL Non-Facility Related						$	$			$ (27,804)	14
15	TOTALS (line 9+line14)						$ 7,814,000	$ 5,884,760			$ 198,294	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 23,721 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: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 71,000	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.)	2017	$ 69,013	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,987)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 71,100	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
	Alloc Fr. Mgmt Co.	3,212	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 72,325	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2014	58,624	8
2015	60,951	9
2016	65,185	10
2017	68,448	11
2018	69,013	12

2018 Tax Accrual = 69,013*1.03 = 71,117.09. Use 71,100

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-07.0-300-005	Long term care property	$ 69,012.56	$ 69,012.56
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 41,655.95	$ 3,212.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 110,668.51	$ 72,224.56

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/18 Ending: 12/31/18

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: 1/1/18 Ending: 12/31/18

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	$ 127,679	$ 127,679	$ 2,458,246	4
5						-		-			5
6						-		-			6
7						-		-			7
8	Allocated from Management Co.		1995		33,372	-		954	954	22,555	8
	Improvement Type**										
9	Various		1994	1994	22,304	58	20	-	(58)	22,304	9
10	Various		1995	1995	52,604	107	20	-	(107)	52,604	10
11	Various		1996	1996	2,492	-	20	-		2,492	11
12	Various		1997	1997	11,349	-	20			11,349	12
13	Various		1998	1998	14,511	227	20		(227)	14,511	13
14	Various		1999	1999	83,394	-	20	4,170	4,170	81,379	14
15	Parking Lot		2000	2000	2,830	-	20	142	142	2,600	15
16	Sprinkler System		2000	2000	3,385	87	20	169	82	3,157	16
17	Sprinkler System		2000	2000	5,820	149	20	291	142	5,456	17
18	A/C Repairs		2000	2000	1,018	-	10	-		1,018	18
19	Ac Repairs		2000	2000	1,102	-	20	55	55	1,023	19
20	Draperies		2000	2000	1,052	-	20	53	53	964	20
21	Carpeting		2000	2000	1,578	-	20	79	79	1,475	21
22	Air Handler		2000	2000	1,786	-	20	89	89	1,650	22
23	Air Conditioner		2000	2000	1,963	-	7	-		1,324	23
24	Air Handler		2000	2000	1,241	-	20	62	62	1,147	24
25	Air Conditioner		2000	2000	1,029	-	20	51	51	955	25
26	Compressor		2000	2000	1,800	-	20	90	90	1,710	26
27	Booster Heater		2000	2000	1,675	-	20	84	84	1,595	27
28	Air Conditioner		2000	2000	5,821	-	20	291	291	5,335	28
29	Air Conditioner		2000	2000	17,320	-	20	866	866	16,093	29
30	Air Conditioner		2001	2001	3,630	-	20	182	182	3,212	30
31	Air Conditioner		2001	2001	3,630	-	20	182	182	3,212	31
32	Air Conditioner		2001	2001	3,111	-	20	156	156	2,753	32
33	Blinds		2001	2001	1,212	-	20	61	61	1,085	33
34	Sprinkler Repair		2001	2001	1,609	-	20	80	80	1,430	34
35	Sprinkler Heads		2001	2001	2,145	-	20	107	107	1,892	35
36	Pipes Repair		2001	2001	1,903	-	20	95	95	1,624	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: 1/1/18 Ending: 12/31/18

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	7,999	43
44	Dry Value System	2003	5,623	144	20	281	137	4,380	44
45	Landscaping	2003	8,800	325	20	440	115	6,747	45
46	Nursing Stations	2003	35,000	-	20	1,750	1,750	26,396	46
47	Repair Fire Protection Equipment	2003	1,694	-	20	85	85	1,359	47
48	P.A. Amplifier	2003	713	-	20	36	36	574	48
49	Security Systems	2004	23,268	901	20	1,163	262	16,866	49
50	16 Transmitters	2004	1,517	-	20	76	76	1,101	50
51	Nurses Stations	2004	35,000	-	20	1,750	1,750	25,375	51
52	Wardrobe units w/ Installation	2004	46,731	2,972	20	2,337	(635)	33,884	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	58,009	53
54	Air Conditioners	2005	20,666	-	7	-		20,666	54
55	Freezer Door	2005	2,100	-	20	105	105	1,418	55
56	Wallpaper	2005	16,140	-	5	-		16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	3,741	57
58	Painting and Wallcovering	2005	38,520	-	5	-		38,520	58
59	Air Condensors	2005	6,270	228	20	314	86	4,237	59
60	Vinyl Flooring	2005	5,009	182	5	-	(182)	5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	414	15	467	53	6,303	61
62	Metal Doors	2005	1,926	70	20	96	26	1,297	62
63	Kitchen Floor	2006	10,300	375	20	515	140	6,438	63
64	Sprinkler System	2006	9,529	347	20	476	129	5,952	64
65	Door Monitors & Paging System	2006	811	-	20	41	41	511	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	2,613	66
67	6 A/C Units	2006	2,576	-	20	129	129	1,612	67
68	6 A/C Units	2006	2,576	-	20	129	129	1,612	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	2,950	69
70	TOTAL (lines 4 thru 69)		$ 5,970,374	$ 10,684		$ 151,693	$ 141,009	$ 3,054,219	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: 1/1/18 Ending: 12/31/18

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		$ 5,970,374	$ 10,684		$ 151,693	$ 141,009	$ 3,054,219	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	2,313	2
3	Duct Heater	2006	1,349	49	20	67	18	839	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	5,761	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,106	20	2,895	789	33,293	5
6	4 Hot Water Heaters	2007	13,462	442	20	673	231	7,740	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,435	20	1,973	538	22,688	7
8	Repair Sprinkler System	2007	3,957	-	20	198	198	2,277	8
9	Oak flooring	2008	15,571	566	20	778	212	8,179	9
10	Fire alarm system	2008	8,858	322	20	443	121	4,651	10
11	Street and parking lot paving	2008	43,360	1,280	20	2,168	888	22,764	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	2,478	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	20,738	13
14	Replace pipe and fitting	2009	4,232	154	20	211	57	2,014	14
15	Air Handling Equipment	2010	22,154	806	20	1,108	302	9,418	15
16	Plumbing Value	2011	4,600	167	20	230	63	1,725	16
17	Hot water system	2011	6,900	251	20	345	94	2,588	17
18	Sprinkler Work	2011	20,035	729	20	1,002	273	7,931	18
19	Direct TV system Installation	2011	7,000	-	20	350	350	2,625	19
20	Handicap shower stall	2011	2,955	107	20	148	41	1,109	20
21				-		-			21
22	71 Gallon Hot Water Heater: Nurse Station Mechanical Room	2012	3,388	123	20	169	46	1,102	22
23	100 Gallon Hot Water Heater: Dietary/Maint. Electrical Room	2012	4,917	179	20	246	67	1,598	23
24	Lighting - Electrical Work: All Resident Rooms	2012	9,975	363	20	499	136	3,242	24
25	Fire Alarm: Whole Facility	2012	6,434	234	20	322	88	2,064	25
26				-		-			26
27	81 Gallon Hot Water Heater	2013	4,624	-	7	661	661	3,909	27
28	New Door	2013	3,094	-	7	442	442	2,247	28
29	100 Gallon Hot Water Heater:	2013	6,236	-	7	891	891	4,455	29
30				-		-			30
31				-		-			31
32	Belt Drive Rooftop Ventilator	2014	3,197	-	10	320	320	1,412	32
33	Countertop and Back Splash	2014	5,593	-	10	559	559	2,750	33
34	TOTAL (lines 1 thru 33)		$ 6,326,747	$ 22,075		$ 171,247	$ 149,172	$ 3,238,125	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: 1/1/18 Ending: 12/31/18

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		$ 6,326,747	$ 22,075		$ 171,247	$ 149,172	$ 3,238,125	1
2	7 Electric Door Holder/Closers	2015	10,102	-	20	505	505	1,768	2
3	Walk Path Improvements	2015	15,874	-	20	794	794	2,778	3
4	Hot Water Heater	2015	3,569	130	5	714	584	2,499	4
5				-		-			5
6	Siding for Cupola	2016	3,677	134	20	184	50	460	6
7	Clinic Service Sink Replacement	2016	3,909	142	20	195	53	489	7
8	2 Hot Water Heaters - Mechanical Room	2016	12,531	456	5	2,506	2,050	6,266	8
9	Hot Water Heater - Nurses Station	2016	7,050	256	5	1,410	1,154	3,525	9
10	Time Clock - 400 Hall in back of building by break room	2016	9,277	890	5	1,855	965	4,639	10
11	4 Custom Duct Heaters 200, 300, 400 & 600 halls	2016	3,650	350	5	730	380	1,825	11
12				-		-			12
13	Walk-In Cooler - Kitchen	2017	18,495	673	20	925	252	1,233	13
14	Install Fire Alarm	2017	3,430	125	20	172	47	258	14
15	98 gallon Water heater	2017	13,801	502	5	2,760	2,258	4,830	15
16	Install Sprinkler System - Entire Building	2017	250,800	-	20	12,540	12,540	18,810	16
17	Plan Submission Fee for Sprinklers - Entire Building	2017	3,010	109	5	602	493	1,154	17
18				-		-			18
19	Furnish & Install Building Front Doors - Main Exterior Entrance	2018	4,822	95	20	121	26	121	19
20									20
21									21
22									22
23	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	3,735	-		-		3,735	23
24	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	622	-		-		622	24
25	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	721	-		-		721	25
26	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	616	-		8	8	616	26
27	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,712	-		86	86	1,633	27
28	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	3,541	-		177	177	2,390	28
29	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	2,005	-		100	100	1,153	29
30	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	4,185	-		209	209	1,988	30
31	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	2,234	-		112	112	614	31
32	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	2,254	-		113	113	507	32
33	Allocated from SW Financial Services Co. - Leasehold Improveme	2015	463	-		31	31	108	33
34	TOTAL (lines 1 thru 33)		$ 6,712,831	$ 25,937		$ 198,094	$ 172,157	$ 3,302,864	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: 1/1/18 Ending: 12/31/18

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	$ 137,521	$	$ 23,659	$ 23,659	5-10	$ 110,392	71
72	Current Year Purchases	6,246	6,246	348	(5,897)	5	348	72
73	Fully Depreciated Assets	875,467				5-10	875,467	73
74	Allocated from Management Co.	14,118		455	455	5-10	10,356	74
75	TOTALS	$ 1,033,352	$ 6,246	$ 24,462	$ 18,216		$ 996,563	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2011 Chevy Express Van	2011	$ 40,007	$ -	$ -	$ -	5	$ 40,007	76
77					-	-	-			77
78					-	-	-			78
79	Allocated from Management	2017 Land Rover Evoque	2017	8,174	-	1,635	1,635	5	2,452	79
80	TOTALS			$ 48,181	$	$ 1,635	$ 1,635		$ 42,459	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)	$ 8,144,364	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,183	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,191	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 192,008	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,341,886	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 57 Description: Respiratory Equipment $57
(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.		$	$ 987	17
18					18
19					19
20					20
21	TOTAL		$	$ 987	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: 1/1/18 Ending: 12/31/18

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: 1/1/18 Ending: 12/31/18

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	$	4,777	$ 343,927	$	4,777	$ 343,927	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,094	100,514		2,094	100,514	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		4,889	312,872		4,889	312,872	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				61,507		61,507	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					14,199		14,199	12
13	Other (specify):									13
14	TOTAL			$	11,759	$ 757,313	$ 75,706	11,759	$ 833,019	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.

STATE OF ILLINOIS

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 282,017	$ 419,589	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 91,618)	2,229,373	2,229,373	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,760	50,997	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,231,038	1,445,198	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,781,188	$ 4,145,157	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		5,298,551	14
15	Leasehold Improvements, at Historical Cost	788,713	1,414,280	15
16	Equipment, at Historical Cost	271,814	1,081,533	16
17	Accumulated Depreciation (book methods)	(640,524)	(4,341,886)	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)**	$ 420,003	$ 3,862,395	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,201,191	$ 8,007,552	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 44,685	$ 52,465	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,698	33,698	28
29	Short-Term Notes Payable	797,844	797,844	29
30	Accrued Salaries Payable	191,144	191,144	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,318	16,318	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,100	32
33	Accrued Interest Payable		15,632	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	396,785	99,180	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,480,474	$ 1,277,381	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,086,916	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)**	$	$ 5,086,916	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,480,474	$ 6,364,297	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,720,717	$ 1,643,255	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,201,191	$ 8,007,552	48

*(See instructions.)

Facility Name: **Caseyville Nursing & Rehabilitation Center, Inc.**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/18**

Schedule 17A

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

Description	Operating	After Consolidation
Re Escrow - Insurance	-	27,809
Re Escrow-Mip	-	36,090
Re Replacement Reserve	-	117,111
Re Escrow- Real Estate Tax	-	33,150
Due From State - Interest	220,142	220,142
Short Term Loan Exchange	1,188,502	1,188,502
Due/From Caseyville Prop. Llc	(177,606)	(177,606)
Total - Line 9	**1,231,038**	**1,445,198**

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

Description	Operating	After Consolidation
Due From State	105,922	105,922
Reimbursement Due	(13,200)	(13,200)
Accrued Expenses	293,742	293,742
Re Due To Lessor - Related Party	-	(297,605)
Insurance Premiums Payable	10,321	10,321
Total - Line 36	**396,785**	**99,180**

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,841,443	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,841,443	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(240,723)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	120,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(3)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (120,726)	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)**	$ 2,720,717	24 *

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 5,931,129	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,931,129	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	880,223	6
7	Oxygen	9,020	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 889,243	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	111	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 111	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,721	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,721	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,523	28
28a	Medicaid Income Adjustment	(8,703)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (5,180)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,843,024	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,311,772	31
32	Health Care	2,318,320	32
33	General Administration	1,638,365	33
	B. Capital Expense		
34	Ownership	628,142	34
	C. Ancillary Expense		
35	Special Cost Centers	872,032	35
36	Provider Participation Fee	315,116	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,083,747	40
41	**Income before Income Taxes (line 30 minus line 40)****	(240,723)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (240,723)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,400,967	44
45	Private Pay - Net Inpatient Revenue	835,509	45
46	Medicare - Net Inpatient Revenue	628,559	46
47	Other-(specify) Hospice	66,094	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,931,129	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.**

^ **Entity is a cash basis taxpayer**

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,963	2,160	$ 86,226	$ 39.92	1
2	Assistant Director of Nursing	240	240	13,775	57.40	2
3	Registered Nurses	6,147	6,473	201,768	31.17	3
4	Licensed Practical Nurses	24,496	26,505	722,241	27.25	4
5	CNAs & Orderlies	72,440	77,781	1,073,552	13.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	185	193	2,118	11.00	8
9	Activity Director					9
10	Activity Assistants	4,785	5,468	76,513	13.99	10
11	Social Service Workers	1,938	2,017	40,430	20.05	11
12	Dietician					12
13	Food Service Supervisor	2,030	2,302	59,131	25.69	13
14	Head Cook	7,289	7,980	111,395	13.96	14
15	Cook Helpers/Assistants	13,008	13,793	130,407	9.45	15
16	Dishwashers					16
17	Maintenance Workers	5,560	6,153	150,647	24.48	17
18	Housekeepers	13,671	14,648	160,163	10.93	18
19	Laundry	9,707	10,513	96,107	9.14	19
20	Administrator	1,824	2,080	102,337	49.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	13,486	14,433	367,295	25.45	23
24	Clerical	4,776	5,340	83,915	15.71	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)	183,542	198,077	$ 3,478,020 *	$ 17.56	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	$ 6,792	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,141	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)		$ 14,733		49

C. CONTRACT NURSES

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

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Geralyn Isenberg	Administrator	0	$ 102,337
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,337

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 258,060
(Eliminated on Sch V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 258,060
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hepler Broom LLC	Legal	$ 17,587
SB2 Inc.	Legal	19,181
Polsinelli	Legal	1,697
RSM US	Accounting	22,045
Unemployment Consultants, Inc.	U/E Consultant	1,900
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 62,410

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,669
Unemployment Compensation Insurance	19,989
FICA Taxes	255,994
Employee Health Insurance	106,481
Employee Meals	23,738
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	3,158
Employee Life Insurance	(4,588)
Tution Reimbursement	500
TOTAL (agree to Schedule V, line 22, col.8)	$ 457,941

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 312)	3,747
Patient Background Checks 200	2,000
Miscellaneous Inspections & Licenses	1,498
Miscellaneous Dues & Permits	3,497
Illinois Council on Long Term Care	19,850
Allocated from Management Co	391
Less: Lobbying Fees	(9,925)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,058

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,000
Allocated from Management Co.	34
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,034

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Caseyville Nursing & Rehabilitation Center, Inc.**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
From page 21 Professional fees		**62,410**
	Total (agree to Schedule V, line 19, column 3)	62,410
Allocated from Management Company	Others	1,088
Allocated from Management Company	Legal Fees	35
Allocated from Real Estate Entity	Professional Services	8,000
Less: Non-Allowable Legal Fees		(912)
	Total (agree to Schedule V, line 19, column 8)	70,621

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center, Inc. # 0039644 Report Period Beginning: 1/1/18 Ending: 12/31/18

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-$19,850**

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,878** 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. $ **315,116**
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. $ **23,738** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.